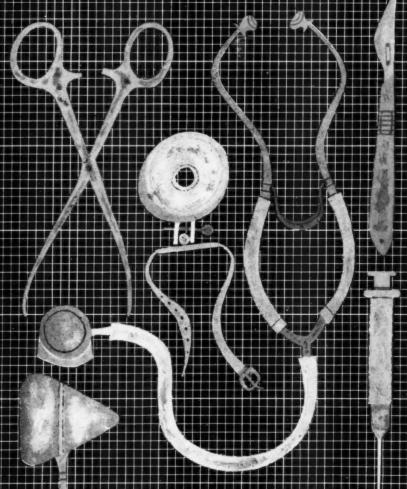
## Medical Economics

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1. Eichner, E., Goler, G. G., Sharzer, S., and Horowitz, B.: Obst. & Gynec. 6:511, 1955. 2. Greenblatt, R. B., and Brown, N. H.: Am. J. Obst. & Gynec. 63:1361, 1952.

## **Medical Economics**

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, MAY, 1957

#### SPECIAL FEATURES

#### 

Here's what's different about every major specialty. Most of the facts are drawn from MEDICAL ECONOMICS' 8th Quadrennial Survey

#### 

People look to health insurance to cover nearly all their medical expenses. They've found that it covers far less than half, says this writer

#### Four Problems That Medicine Must Solve .......146

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-MORE

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#### 

That fun-loving alcoholic blonde made quite a nuisance of herself at the county hospital—a fatal nuisance

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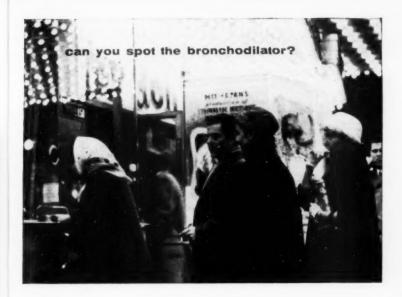
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## News

#### Doctors Found Sicker Than Expected

The need of doctors to have annual physical checkups has been dramatically demonstrated in Brooklyn, N.Y. At a regular meeting of the Kings County Medical Society, fifty-nine member physicians were chosen at random to take a battery of simple tests: blood, urine, X-ray, ECG, etc. The surprising results are shown in the table below. The figures show only the number of doctors in each category who did not already know of their condition:

Definite heart disease		0				10
Possible heart disease						8
Hypertension			0			9
Blood disturbance						12
Recent lung disease .			0	۰	۰	2
Remote lung disease .	0	0	0	0		7
Urine: sugar						1
Urine: albumin	0	۰				3

The tests were arranged by the society's public health committee. The testing method, as explained

by the committee chairman, Dr. Harry S. Lichtman, was this:

Each of the fifty-nine doctors "was given a survey number, which gave his examination anonymity

. . . X-rays were read by a team of roentgenologists ... Similarly the blood smears were read by a team of hemotologists; the ECG's by a team of cardiologists. Finally, the history and all findings,



Lichtman

including the opinions of the experts, were submitted to a team of internists for evaluation . . . This summary opinion and all findings were then mailed to each of the doctors examined."

The results have convinced Dr. Lichtman that such tests should become a regular part of the medical society's program. His committee has unanimously recommended that they "be continued on an annual basis, but on a more comprehensive scale . . . A full day, preferably election day at the society, [should] be set aside for this purpose."

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#### M.D. Warns Colleagues About Drug Addiction

Think your chances of becoming a drug addict are only one in a thousand? If so, you're wrong. Dr. J. DeWitt Fox of Detroit, Mich., says the odds are 1:100.

Nor is it only the "'no-account' [doctor] with no brains and no future in medicine who takes to the needle," Dr. Fox says. Writing in the Journal of the Michigan State Medical Society, he reports on a California physician who graduated magna cum laude from his medical school and then took a residency and research fellowship with one of the nation's top scientists:

"Under the strain of post-graduate study he became tense . . . He started taking barbiturates to get his rest at night. But these didn't do the job. One night he decided to try a little Demerol. It worked well... The doctor had found just what he needed. He had easy access to the drug in the laboratory, and soon he was taking more and more. It wasn't long until he was discovered and was immediately discharged from his fellowship. He set up practice in a small town, where he failed miserably because he continued to take narcotics. He is in an institution today."

Another physician told Dr. Fox

this story: "One evening I came home tired out. My back was aching, my feet were sore and swollen. But I had promised my fifteen-year-old daughter I'd take her roller-skating. I was



Fox

sure I wouldn't be able to put on a pair of skates if I didn't do some-

#### Snapshots

YOUR DOORBELL may ring this month in connection with the nationwide sickness survey of the Public Health Service. A sampling of answers given by patients needs to be cross-checked against medical records. M.D.s are being asked to cooperate.

ONE EQUALS TWO, the 550 happy residents of Utica, Neb. learned recently. They'd been searching for a doctor, finally lured Dr. Wilmar Kamprath. With him came another M.D.-his wife. The duo work in a brand-new building erected by the villagers.

LOOKING FOR A JENNER in the rough, the British College of General Practitioners is inviting G.P.s of all countries to submit "ideas or hunches on the cause, diagnosis, treatment or prevention of any disease." The B. C. G. P. thinks genius may be hiding under some country doctor's modest shingle.

HIS WIFE SNORED SO that he could hear her in an adjoining room with the door closed. What to do? Counseled the medical news columnist, Dr. Edwin P. Jordan: "Get some ear plugs."

thing for the pain. Surreptitiously I went into the bedroom, took a vial of Demerol from my bag, and gave myself a shot. I went skating and felt swell . . . That started me off. I had found an escape from my pain and fatigue."

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At an Eastern hospital, Dr. Fox continues, "a regular epidemic occurred: Within the space of a few vears no less than five internes ended up as dope addicts." Even a medical school dean, he adds, recently had to enter the Federal hospital in Lexington, Ky. to cure his addiction.

A study of about fifty doctor-addicts admitted to the Federal hospital in Fort Worth, Tex., says the physician, shows that the typical addict "is married, has two children, and practices in a small urban or rural community. He begins using drugs at the age of thirty-nine and his addiction lasts thirteen years, during which time he makes three voluntary attempts at cure."

He quotes Dr. Harris Isbell, director of the Federal hospital in Lexington, as saying that typical doctor-drug addicts start taking narcotics for one of three reasons: to relieve frequent alcoholic hangovers; to blot out habitual fatigue; or to ease the pain from some disease. But, he quotes Dr. Isbell as adding, "we always find a serious emotional disorder in the background." This, says Dr. Fox, "may be anything from a marital rift to income tax trouble . . . What most physicians need is a good night's sleep, more vacation time, release from tension, a quiet place for meditation."

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What doctors also need, says Dr. Fox, is more instruction about the dangers of drug addiction: "It is high time that medical schools begin telling students the dangers and pitfalls they will face once they get a narcotic license," he says. ". . . It is time every doctor-you and me-and every medical student-be told the 'facts of life'" about narcotic addiction.

One institution that is instructing its students about narcotics is the University of Maryland Medical School, says Dr. Fox. Every year, the U.S. Commissioner of Narcotics lectures future doctors there on the potential dangers of drugs; some of those lectures will soon be filmed for distribution to other schools.

#### M.D. Loses Suit Against Pro-Fluoridationists

In the fluoridation battle being fought all across the country, one of the more curious episodes has taken place in Chehalis, Wash. There a leading anti-fluoridationist has lost an unusual lawsuit he brought against a pro-fluoridation group.

The lawsuit had its genesis in a fluoridation referendum held in

#### Snapshots

A CLERICAL MISCARRIAGE almost kept a perfectly healthy male from re-enlisting in the U.S. Navy: His record showed he had been discharged as pregnant. "As far as I know," the gob grinned, "I've never been."

A MEDICAL BOYCOTT threatened by M.D.s in Oklahoma City against a V.A. hospital-unless it stops admitting insured veterans with non-service-incurred illnesses -has been put off "until Congress has had time to pass remedial legislation." But the delay, local doctors warn, is only a "temporary postponement."

A GRINNING HUMAN SKULL, strategically placed, makes an effective burglar alarm. At least such a skull appears to have been the main deterrent when a thief broke into the Indianapolis home of Dr. B. Kemper Westfall Jr., then beat an empty-handed retreat.

TO INFLUENCE LEGISLATORS in Congress last year, the A.M.A. spent \$48,000. The American Dental Association, for the same purpose, took an even bigger bite out of its budget: \$55,400.

Chehalis in May, 1955. Throughout a bitter campaign, one of the leading spokesmen for the antifluoridationists was Dr. Frederick B. Exner, a Seattle radiologist. Dr. Exner (who is immediate past president of his county medical society) opposes fluoridation chiefly because he believes it infringes upon personal liberties; but also because he's convinced it's medically harmful.

Partly because of his efforts, Chehalis voters decided not to add fluorides to their drinking water.

During the campaign, Dr. Exner came across a handbill in which the Chehalis Fluoridation League offered \$1,000 to anyone who could prove that fluorides in the proportion of one part per million had ever had an "ill effect" on anybody anywhere. Dr. Exner promptly



DR. FREDERICK B. EXNER tells New York what's wrong with fluoridation.

claimed the reward—but promised he'd withdraw his claim if the league would retract its offer before the election. It didn't; and when it also refused to pay him the \$1,000, he sued.

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At the trial, he cited several cases in Colorado where he said fluorides in *less* than one part per million had "disfigured" teeth and caused "lesions." To refute this, the fluoridation league brought in Dr. Frederick McKay, Colorado Springs dentist sometimes referred to as "the father of fluoridation," and Dr. Robert Downs of the Colorado Health Department.

In his ruling, the judge gave the Colorado witnesses' testimony as his principal reason for deciding in favor of the fluoridation league. He added that even if fluorides were proved to have caused "disfigured" teeth, no one had testified that this was necessarily an "ill effect." Dr. Exner's suit was dismissed "with prejudice"—which means it can't be brought again on the same facts.

Undaunted by this decision against him (which he's appealing), Dr. Exner is vigorously continuing his campaign against fluoridation. Just off the presses is a new book he wrote with Dr. George L. Waldbott of Detroit; it's called "The American Fluoridation Experiment." And in New York City, he recently appeared at a public hearing to denounce the city's

fluoridation proposals as "transparent nonsense" and "pseudoscientific balderdash."

#### A.A.G.P. Redefines What A Generalist Is

As far as the American Academy of General Practice is concerned, the term "G.P." now applies only to "family physicians."

Hitherto, a general practitioner has been defined officially as "one who does not limit himself to one field of medicine or surgery." That statement was accepted by the A.M.A. in 1946 and by the A.A.G.P. when it was organized in 1947.

But at its recent meeting in St. Louis, the Academy formally redefined general practice. Henceforth, it is "that area of medical care performed by a doctor of medicine in those fields of diagnosis and therapy commensurate with his professional competence, assuming a total continuing responsibility for the health of the individual or the family as a unit."

The need for the new statement was presented to the Academy by Dr. John S. DeTar, outgoing A.A.G.P. president. Inquiries by Dr. DeTar had turned up no less than sixty-eight definitions—"the very existence" of which, he pointed out, "is evidence of the desirability . . . of a standard definition . . . [MORE]

## "SUDDENLY



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 Gale, E. T., and Thewlis, M. W.: Geriatrics 8:80, 1953.
 Alvarez, W. C.: Geriatrics 10:555, 1955.
 Conference on Cerebral Vascular Disease, American Heart Association, Princeton, N. J., January, 1957.

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"Such a definition," he went on. "should define the responsibility of the generalist. It should accent his role as the family physician. It should eliminate from the field of general practice all... who are not in truth family physicians."

Dr. DeTar is convinced that the new statement meets all these objectives. "We are proposing to the three A.M.A. committees now considering a definition of general practice, that they go along with this definition," he says. "We are confident that they will. [And we expect] it will be submitted . . . for approval by the A.M.A. House of Delegates in June."

## French Physicians Fight Fixed-Fee Program

Angry French doctors are making headlines. Letters from scores of them have appeared in recent editions of Paris newspapers—all vigorously denouncing Minister of Social Affairs Albert Gazier.

Reason for the doctors' indignation: The French National Assembly has been considering a Government-backed proposal for fixing physicians' maximum fees. And the proposed fees would be set much lower than those now in effect.

At present, office visits are likely to cost French patients the equivalent of from \$3 to about \$5.50. Some 50 cents of this charge is met by Government social security. Under the new schedule, the physician could charge no more than \$1.90

of choice from any angle Ease of use Trouble-free. long life Precise diagnosis almoscopes Otoscopes

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for an office call; and the state would reimburse the patient for up to 80 per cent of it.

All other medical fees would be standardized at similar low levels.

This program, asserts the doctors' Confederation of French Medical Syndicates, would "upset the necessary liberal character of the medical profession and gravely modify the doctor-patient relationship." And in a widely circulated pamphlet, the medical men have been fighting "unionization" by emphasizing that they are "not plumbers."

Albert Gazier obviously disagrees. Speaking for France's current Government, he has called the

fixing of medical fees by private agreement between physician and patient "universally outdated."

#### Editor Attacks 'Shotgun' Malpractice Suits

Newspaper coverage of medical malpractice doesn't often make pleasant reading for doctors. But it did recently in California. Alexander Bodi, editor of The Palo Alto Times, devoted his daily editorial column to a sweeping criticism of what he calls the "shotgun" method of suing doctors.

The idea of such lawsuits is to "aim at everybody in sight," he says, "and hope to hit . . . somebody

ideal... A when dermatoses are in bloom

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topical ointment

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#### NEOMYCIN + the first water-soluble dermatologic corticoid

outstanding availability, penetration, therapeutic concentrations and potency - without systemic involvement. In 1/2-oz. and 1/6-oz. tubes, 0.5% neomycin sulfate and 0.5% ethamicort (MAGNACORT).

#### for inflammation without infection MAGNACORT topical ointment

In 1/2-oz. and 1/6-oz. tubes, 0.5% ethamicort (hydrocortisone ethamate hydrochloride).



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MEDICAL ECONOMICS · MAY 1957 23

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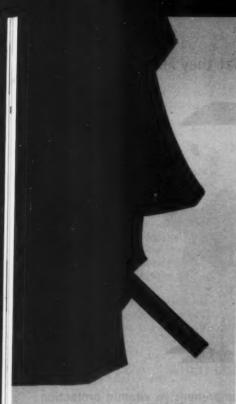
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when he smokes too much...

relieve habit-induced gastric hyperacidity with

**GELUSIL** 

refreshingly flavored, nonconstipating antacid

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with enough dough to pay." In case someone's named as a defendant who had nothing to do with the case, the complaint can be amended later, he points out; but from the doctor's standpoint "the harm done cannot be offset later."

In a recent claim for alleged wrongful death, reports Bodi, "one of the doctors named as a defendant says that he was not called into the case and never saw the patient. Another, according to the medical society, was out of town and had not seen the patient since 1949. A third, it is alleged, was only called in to perform the autopsy and never saw the patient when she was alive. As one of the doctors involved pointed out, even the most cursory investigation could have revealed these facts."

Bodi explains to his readers that "a doctor's reputation is his principal asset, next to his actual ability. He's sensitive about it, and rightfully so. Any attack on his reputation, even though later shown to be unwarranted, may cause some of his patients to have doubts about his ability...

"I don't know what the answer is." Bodi concedes. "Perhaps the plaintiff who loses his suit should be made to pay damages to the defendant. At any rate . . . the shotgun method of selecting defendants [is] a problem that . . . the medical and legal professions should get together on." After all, he concludes, "they're [both] serving the same people." [MORE NEWS ON 331]



Your restless patients' sleep problems
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- "The general practitioner likes it . . ."
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Current Concepts in Therapy: Sedative-Hypnotic Drugs. II. Chloral Hydrate. New England J. Med. 255:706 (Oct. 11) 1956.

adults: 1 or 2 7½ gr. capsules or 1 or 2 teaspoonfuls of Noctec Solution 15 to 30 minutes before bedtime.

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7½ and 3¾ gr. capsules, bottles of 100. Solution, 7½ gr. per 5 cc. tsp., bottles of 1 pint.

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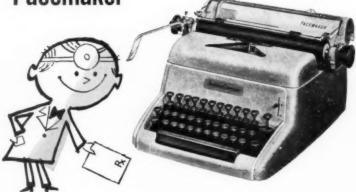
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"In acute and chronic recurrent low back syndrome, seven of eight patients showed visible objective improvement."

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#### How Supplied

Pink, Enteric Coated tablets (250 mg.), bottles of 36. Yellow, scored tablets (250 mg.), bottles of 50.

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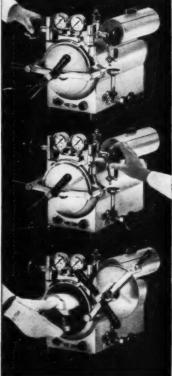
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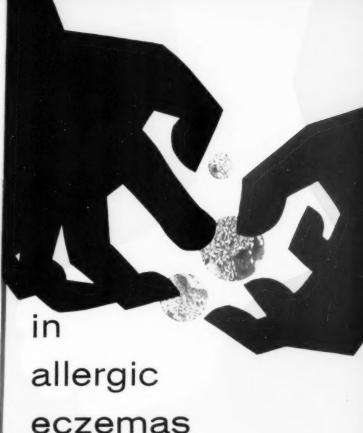
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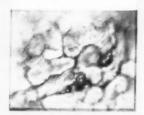
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water washable – stainless benefits allergic dermatoses, usually without irritation

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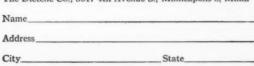
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Aspirin buffered with Maalox®

Ascriptin® tablets:

- 1. Produce double the salicylate blood level dose for dose . . . compared with plain aspirin.\*
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Indicated: Any conditions where salicylates are useful.

Dosage: Same as aspirin.

Formula: Each ASCRIPTIN tablet contains:

ACETYLSALICYLIC ACID. . 0.30 Gm. Maalox<sup>8</sup> . . . . . . . . . 0.15 Gm. (Magnesium aluminum hydroxide gel)

Degrees of pain relief are difficult to measure. We'll be glad to send you samples of ASCRIPTIN tablets with our compliments and you may make your own comparisons.

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#### stops poison ivy itching even before it starts

prevents Rhus dermatitis when applied prophylactically relieves existing dermatitis when applied 3 or 4 times a day

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LOTION

(tripelennamine hydrochloride and zirconium oxide CIBA)

Antivy Lotion works two ways to combat Rhus dermatitis: (1) Pyribenzamine, an established antipruritic, promptly stops itching and edema. (2) Zirconium oxide specifically neutralizes Rhus toxin, preventing development or spread of lesions.

#### HOW TO USE-

As a prophylactic measure: Apply Antivy generously to exposed areas of the skin and rub in gently whenever contact with Rhus plants is anticipated or as soon as possible after contact.

As a therapeutic measure: Apply generously to the affected area and rub in gently 3 or 4 times a day.

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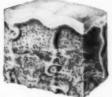


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for natural acceptance of your prescribed contraceptive regimen • fulfills your patient's natural wish that her possessions reflect her femininity. Each Lanteen Exquiset contains: 3 oz. tube of Lanteen spermicidal jelly, soothing, cleanly scented; easy-to-insert, molded, flat spring diaphragm; newly designed Easy-Clean applicator; universal inserter — all fitted into a stylish, soft plastic purse.

Lanteen jelly contains ricinoleic acid 0.50%, hexylresorcinol 0.10%, chlorothymol 0.0077%, sodium benzoate and glycerin in a tragacanth base. Lanteen jelly and flat-spring diaphragm sets are distributed by George A. Breon & Company, 1450 Broadway, New York 18, N.Y. (in Canada: E. & A. Martin Research Ltd., 20 Ripley Ave., Toronto, Canada.) Manufactured by Esta Medical Laboratories, Inc., Chicago 38, Ill. \*\*\*RADEMARK O' GEORGE A. BREON & COMPANY

Acute inflammation



Note spread of suppuration throughout the tissues and a marked swelling from surrounding edema.

Acute inflammation after starting Chymar therapy.



Note regression of edema and swelling.

Chymar

the newest and SAFEST anti-inflammatory agent

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# Chymar

What it is ...

Chymar is a suspension of the proteolytic enzyme chymotrypsin in oil, for intramuscular use.

What it does ...

Chymar reduces and prevents inflammation irrespective of cause; reduces and prevents edema of inflammatory and traumatic origin; reduces pain; hastens absorption of blood and lymph effusions; restores circulation; promotes healing.

Why CHYMAR is so safe ...

It causes no undesirable local or systemic reactions; has no known contraindications—no known incompatibilities; has no influence on blood clotting mechanism; does not spread infection, but augments the action of concurrently used antibiotics.

Indications...Prophylactic and Therapeutic

Chymar is indicated in all conditions in which inflammation and edema retard healing. 1) Accidental injuries: Black eyes, bruises, hematomas, wounds, burns, sprains, fractures, bursitis. 2) Surgery: Biopsies, cellulitis, hernia repair, hemorrhoidectomies, G. I. surgery (to prevent edema and hematomas at site of anastomosis), mammectomies, orchitis, epididymitis, prostatitis, phlebitis, thrombophlebitis, skin ulcers (as an adjunct to Tryptar Antibiotic Ointment). 3) Obstetrics: Breast engorgement (postpartum), cephalohematoma, episiotomies. 4) Eye Diseases: Inflammation, trauma, edema, hematomas (blood in anterior chamber), pre- and postsurgically.

Supply: 5 cc. vials. Each 1 cc. contains 5000 units of proteolytic activity.



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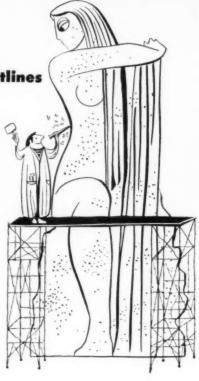
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Even marble may sometimes seem less adamant than those overweight patients whose problems stem from too-high caloric intake...

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Reconstituted, Instant Pet is delicious milk-without-fat ... refreshing as a beverage, an ideal ingredient for cutting calories in foods made with milk. It can be used conveniently, as an ingredient, in dry form. And however used, it supplies only balf the calories of an equal amount of whole milk ... costs as little as 8 cents a quart.



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- Prompt, high blood levels1
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Tablets, 0.5 Gm., bottles of 100 and 1000.

Raspberry-flavored Suspension, 0.5 Gm. per 5 cc. teaspoonful, pint bottles.

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Squibb Quality-the Priceless Ingredient

TERFENYL'S IS A SQUIDE TRADEMARK

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1. Lehr, D.: Modern Med. 23:111 (Jan. 15) 1955.

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"Our results . . . have been so striking . . . dramatic . . . rapid."1

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... with no evidence of toxicity."2

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\*Better tolerated Mol-Iron is now available with vitamin C (75 mg. per tablet), because ascorbic acid has been shown to promote increased absorption of orally administered iron. 15

Desage: Adults—2 tablets t.i.d. after meals.

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Supplied: Bottles of 100 only.

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Well-tolerated—even by patients with a history of iron intolerance.<sup>3, 4</sup>



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More rapid maximal hemoglobin response shortens the period of treatment usually necessary with other preparations.



Outstanding efficacy and tolerance is attested by more original investigations and clinical evaluations<sup>1-14</sup> than have been reported for any other iron preparation.





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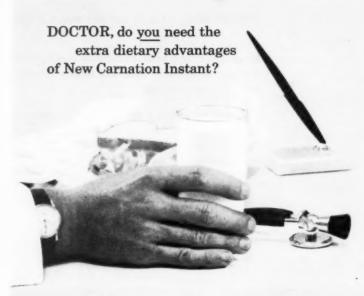
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Dosage: Adults—2 tablets t.i.d. after meals.

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Drops in bottles of 15 and 50 cc. with calibrated dropper.



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#### 24 steps to a hospital bed

The commonest task, such as climbing a flight of stairs, confronts the angina pectoris patient with a fearful question: "Will I be able to make it?"

Exertion leads to attacks . . . and fear of attacks leads to an increasing restriction of activities. Ultimately, even the attack-free intervals may lose all semblance of normal living.

Remove the fear factor. In 4 out of 5 patients, routine prophylaxis utilizing Peritrate reduces the incidence and severity of anginal attacks, improves abnormal EKG tracings and increases exercise tolerance.

A new sense of freedom restores the "cardiac cripple" to a sense of usefulness and participation, although he should not now indulge in previously prohibited strenuous exercise.

Peritrate prophylaxis is simple: 10 or 20 mg. before meals and at bedtime. The specific needs of most patients are met with Peritrate's five convenient dosage forms: Peritrate 10 mg. and 20 mg. tablets; Peritrate Delayed Action (10 mg.) for protection continued through the night; Peritrate with Phenobarbital (10 mg. with phenobarbital 15 mg.) where sedation is also required; Peritrate with Aminophylline (10 mg. with aminophylline 100 mg.) in cardiac and circulatory insufficiency.

Usual Dosage: A continuous schedule of 10 to 20 mg. before meals and at bedtime.

#### **Peritrate**°

(brand of pentaerythritol tetranitrate)

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100 YEARS OF SERVICE TO THE MEDICAL PROFESSION



it is good reason to specify

# CALCINATAL

which gives your patient phosphorus-free calcium, organic iron, balanced high level vitamin and minerals and aluminum hydroxide gel to bind a portion of dietary phosphorus. It's trite to say "our tablets are small and easy to swallow" so write to us for samples in order that you may judge for yourself.

IN BOTTLES OF 120 TABLETS

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# Rauwiloid<sup>®</sup>

#### A Better Antihypertensive

"We prefer to use alseroxylon (Rauwiloid)

> since it is less likely to produce excessive fatigue and weakness than does reserpine." Up to 80% of patients with mild labile hypertension and many with more severe forms are controlled with Rauwiloid alone.

Moyer, J.H.: J. Louisiana M. Soc. 108:231 (July) 1956.

#### A Better Tranquilizer, too

"...relief from anxiety resulted in generally increased intellectual and psychomotor efficiency with a few exceptions."2 Rauwiloid is outstanding for its nonsoporific sedative action in a long list of unrelated diseases not necessarily associated with hypertension but burdened by psychic overlay.

Wright, W.T., Jr., et al.: J. Kansas M. Soc. 57:410 (July) 1956.

Dosage: Merely two 2 mg. tablets at bedtime. After full effect one tablet suffices.

#### Best first step when more potent drugs are needed

Rauwiloid is recognized as basal medication in all grades and types of hypertension. In combination with more potent agents it proves synergistic or potentiating.

Rauwiloid"+Veriloid"

In moderate to severe hypertension this single-tablet combination permits long-term therapy with dependably stable response. Each tablet contains 1 mg. Rauwiloid (alseroxylon) and 3 mg. Veriloid (alkavervir). Initial dose, 1 tablet t.i.d., p.c. Rauwiloid\*+ Hexamethonium

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## Letters

#### 'A Woman's Place ... '

Sirs: In the ten years I've been attending medical conventions, a subtle change has been taking place. A decade ago, meetings were for doctors; now the halls are often almost half full of wives.

At a surgical organization's recent convention, doctors were craning their necks three deep outside a small room where movies were being shown. Yet seated comfortably inside were many wiveswatching the "Technique of Pneumonectomy."

Has this sort of thing changed the quality or subject matter of convention presentations? It has. The first day of the 1956 meeting of the American Academy of General Practice (to which wives were invited) was a program of admitted and proclaimed wife-appeal. The philosophical and cultural topics covered would have been fine for a ladies' magazine; but they hardly repaid a doctor for leaving his practice and driving hundreds of miles . . .

Even at the technical exhibits, there are the ladies. They think it's a bazaar. Some even have shopping bags in which to load the samples. Lately, their audacity has grown to the point where they're bringing the kids along.

A medical convention used to be an occasion for renewing old friendships and talking shop. Now, when you encounter a friend and suggest dinner together, he says: "I'd like to, but I've got my wife along"...

George M. Ellis, M.D. Connersville, Ind.

#### The Doctor's Ideals

Sirs: Allow me to congratulate you on the excellent article by Dr. Stafford L. Warren, "What It Takes to Be a Top Doctor." Dr. Warren's division of doctors into the three categories of mechanic, scientist, and healer might also have included businessman.

I suppose it's impossible for doctors in our western civilization to escape identification with the ma-

chine. Even in my specialty-psychiatry-an increasing number of young men seem to think psychotherapy is a technique that can be learned, rather than a human relationship ...

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I hope we'll see more articles emphasizing the fact that the doctor can be both a scientist and a perceptive human being.

> Henry H. Hart, M.D. Southbury, Conn.

Sirs: I was appalled to read in MEDICAL ECONOMICS of the New York City specialist who reportedly earns a million dollars a year. I wonder what effect this news will have on the following:

1. The idealistic medical student, who is so often cautioned by his peers that he's entering a profession dedicated to service-not starting on another road to riches.

2. The interne or resident, who now sees the choice of specialty training thumpingly vindicated.

3. The harried general practitioner, with his picayune fees, 6year-old car, and burdensome night calls.

4. The conscientious M.D. who has learned he can see only a certain number of patients a year and net only a modest income if he practices good medicine.

5. The public, which is already convinced that physicians prey on patients' pocketbooks in times of physical and mental distress.

6. The officious, governmentspawned investigators who are ever ready to pounce on medical men.

7. Our malpractice rates.

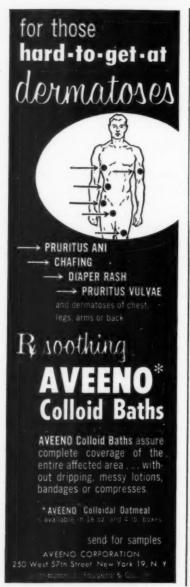
M.D., Massachusetts

#### Medical 'Cavalcade'

Sirs: About a year ago, you published an article called "A Medical Convention for John Q. Public." It stated: "Any medical community that doesn't seriously consider the idea is missing out on a sure-fire

Our county society took the suggestion seriously, and we now heartily endorse it.

We recently staged a three-day



#### LETTERS

"Cavalcade of Medicine" in this city. Unlike some similar shows elsewhere, our was planned exclusively for the laity from the start. And it was a fantastic success.

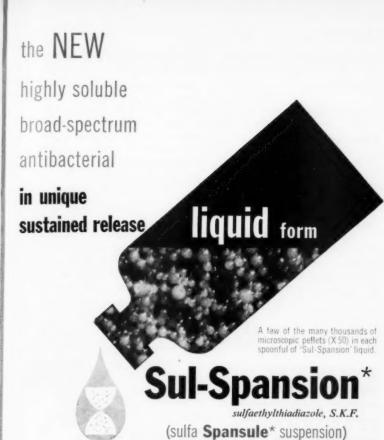
Twenty-five thousand enthusiastic people attended (this, in a town of only 35,000!). Our visitors came from all over Georgia, from thirteen other states, and from five foreign countries. They included classes from seventeen different high schools.

The theme of our Cavalcade was "progress." A series of booths depicted medicine as practiced fifty years ago, 100 years ago, 1,000 years ago—and, of course, today.

The most striking of our fortysix displays was an exact replica of an old country doctor's office, which we built ourselves. We also had three A.M.A. exhibits, nine commercial exhibits, and eight exhibits from such organizations as the American Red Cross, Civil Defense, the Infantile Paralysis Foundation, etc. In addition, there were free movies, free diagnostic tests, and free Coca Colas (15,010 of them, to be exact).

We charged no admission. Our expenses totaled only about \$2,000. The rental from commercial exhibitors covered half that amount; our county medical society paid the rest.

Nothing else in this area has ever been so well received by the public. People say the Cavalcade was the biggest thing to hit Marietta since the Government built the Lock-



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You can be sure your patient is getting optimum antibacterial protection around-the-clock with 'Sul-Spansion', the outstanding new sulfonamide in sustained release liquid form.

Just one dose in the morning and one dose at bedtime maintains therapeutic blood levels (8-15 mg.%) uninterruptedly throughout the day and night...and it's delicious!

made only by Smith, Kline & French Laboratories, Philadelphia

first X in sustained release oral medication

#### LETTERS

heed bomber plant . . . We're grateful to MEDICAL ECONOMICS for giving us the idea.

E. P. Inglis, M.D. President, Cobb County Medical Society Marietta, Ga.

#### Unwelcome Patients

SIRS: As a psychiatrist, I find Dr. I. Jay Schiff's flip attitude toward neurotics (as revealed in "I Built My Practice Around a Pay-by-the-Year Plan") discouraging and somewhat naive.

"I don't accept obvious neurotics in my plan," he says. Well, whether he knows it or not, many of his patients are neurotics. The diathermy, the vitamin injections, and the

heat-lamp treatments he mentions are the tip-off.

And imagine telling a neurotic patient: "The nature of your illness is such that I can't afford to care for you on a yearly-fee basis." What's better calculated to aggravate anxiety or confirm a hypochondriac's belief that he's desperately and incurably sick?

> Henry A. Davidson, M.D. Cedar Grove, N.I.

SIRS: One of your correspondents tells of four ridiculous "ultimatums" his hospital issued to staff physicians. I think it's rather surprising that the list wasn't headed by something like: "This hospital

#### POWER FOR PEAK THERAPEUTIC PERFORMANCE

Potentiated Mephenesin\*

For relief of low back pain and other arthritic pain, for release of tension accompanying pain.

- Relieves pain
- Soothes tension
- · Relaxes muscle spasm Each EXPASMUS tablet contains: Dibenzyl succinate 125 mg., mephenesin 250 mg., salicylamide 100 mg.

Mephenesin physiologically potensified with a smooth muscle relaxant and analgesic . . . dibenzyl succinate

Dosage: 2 to 3 tablets 3 times daily to 12 tablets daily.

Supplied: Bottles of 100's tablets

Request reprints and samples.

Martin H. Smith Co. 131 East 23rd St., New York 10, New York

Manufacturers of ethical products for over half a century

# in seasonal allergies ...as in <u>colds</u>

you can check excessive irritant secretions.

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and "unlock" the closed-up nose

orally with

#### Novahistine<sup>®</sup>

In the management of seasonal allergies and the common cold, Novahistine works better than antihistamines alone. The distinct additive action of a vasoconstrictor with an antihistaminic drug combats allergic reactions more efficiently . . . provides marked nasal decongestion and inhibits excessive irritant secretions. Novahistine eliminates patient misuse of nose drops, sprays and inhalants . . . avoids the risk of rebound congestion. Novahistine will not cause jitters or insomnia.

Each Novahistine Tablet or teaspoonful of Elixir provides 5.0 mg. of phenylephrine HCl and 12.5 mg. of prophenpyridamine maleate. For patients who need greater vasoconstriction, Novahistine Fortis Capsules and Novahistine with APC Capsules contain twice the amount of phenylephrine.

Pitman-Moore Company . Division of Allied Laboratories, Inc. Indianapolis 6, Indiana

#### LETTERS

will admit no patients whose admission would interrupt, infringe upon, or even slightly increase the administrative work-load."

Some of our so-called modern hospitals seem to be managed for the convenience of the administrative staff. The patient is regarded as an intruder and any duties that must be carried out on his behalf are considered a nuisance.

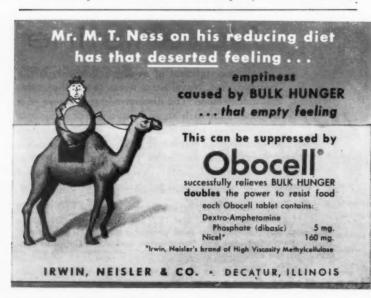
M.D., Ohio

SIRS: In "How to Educate Patients to Parenthood," you quote Dr. Robert N. Rutherford as saying he and his partners refer to marriage counselors those patients "who need more help than we have time

to give." Such a policy does a disservice to medicine ...

The emotional problems of marriage should be handled by a psychiatrist-not by a marriage counselor who may be a psychologist, a social worker, a personnel man, or someone who has majored in counseling in college. Whatever his training, the marriage counselor is an amateur when it comes to tampering with the deeper layers of the human mind. No M.D. should refer people for amateur doctoring.

Perhaps there are special conditions in Seattle that make these counselors more accessible than psychiatrists . . . Still, Dr. Rutherford's policy seems no different



# MEMO



FROM B-D

#### RE Selecting a hypodermic needle

What do physicians look for in a hypodermic needle?

Sharpness, first of all. The ability to take a fine edge and hold it. The toughness to resist breakage. Resistance to rust and stains. Ease of cleaning. Complete uniformity in every needle. And finally, the economy these time- and cost-saving qualities provide.

Through the years, B-D YALE® hypodermic needles have won the preference of critical users everywhere. Not by chance but because unique developments in design and construction have ensured their superior performance.

The Research Department of B-D is continually striving to improve B-D needles, thus assuring the profession of the finest quality needles available for parenteral therapy.



D.D. YALE, T.M. REG. U.S. PAT. OFF.

















#### by changing the attitude of the emotional dermatologic patient,

'Thorazine' facilitates the management of the patient and the treatment of skin disorders, The patient becomes less insistent and frantic, and accepts her affliction philosophically. 'Thorazine' does not cure skin diseases, but, according to Cornbleet and Barsky,1 it is a "most useful adjuvant to dermatologic therapy" in patients with an emotional background of tension, apprehension, excitement, anxiety and agitation.

#### THORAZINE\*

"can be to the dermatologist what the anesthetist is to the surgeon."1

Smith, Kline & French Laboratories, Philadelphia 1. Cornbleet, T., and Barsky, S.: The Role of the Tranquilizing Drugs in Dermatology, presented at 115th Annual Meeting of Illinois State Medical Society, May 19, 1955.

\*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

#### LETTERS

from that of the G.P. who sends patients to an optometrist for refractions, to a midwife for deliveries, or to a lay-operated laboratory for blood tests.

M.D., New Jersey

Dr. Rutherford comments:

"We tried first our psychiatric friends. After dedicated efforts on our part to convince our patients that the psychiatrist treated 'normals' as well as 'abnormals,' we found that the majority of such 'normal' patients were being referred promptly to the psychologist operating through the psychiatrist's own office.

"As a result, we encouraged a competent psychologist to establish himself in our community as an independent practitioner. He has demonstrated his ability to distinguish those patients who will benefit by education at his level from those who should go on to psychiatric evaluation.

"As obstetricians and gynecologists, we feel that we're good one-punch, common-sense counselors. But we're most inadequate to render efficient, inexpensive, long-term counseling. Physicians too can become 'dangerous meddlers'...

"Incidentally, our psychiatric consultants approve of our arrangement as it has evolved."—ED.

#### Physician-Farmers

SIRS: "Should You Buy a Farm as an Investment?" is a fine article. But there's a lot more to be said



So simple

#### you can do your sterilizing blindfolded

When you merely set one dial, your sterilizing is so simple you can do it blindfolded. Sterilizing with a SpeedClave is that easy!

No other office autoclave offers you automatic heating, timing, and venting. Three features that free your nurse for other duties. To sterilize, she merely loads the SpeedClave, sets it . . . then forgets it.

Simple? Nothing could be simpler—or safer. Autoclaving is the safe way to sterilize. And Speed-Claving is the simplest and quickest.

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	me descriptive bulletin DS-246 tells all about the SpeedClave.
Name_	
Addres	8

#### LETTERS

about the doctor-farmer's taxes. In my observation, farming isn't a good way for the doctor "to get his own back" from Uncle Sam on his income tax returns.

In most cases, farming by doctors is hobby farming. And Uncle Sam doesn't approve of schemes to cut down taxable income by deducting losses on an activity carried on primarily for fun. The test the Internal Revenue Service applies is simple: Is the doctor farming not only with the intention of making a profit, but also with a reasonable expectation of so doing?

These things, of course, are hard to prove. But regular losses would surely be taken to indicate lack of

the proper motives. The doctorfarmer should be prepared to show that he tried to make a profit (by selling produce, by switching from one kind of farming to another, etc.).

My advice to would-be doctorfarmers: Don't go it alone. Set up a partnership for the project (possibly with another physician). This will give your farm a tax-identity of its own. As a result, your tax returns will be less likely to be challenged.

Horace Cotton Professional Management Southern Pines, N.C.

Sirs: One important disadvantage

in acute subdeltoid bursitis

relief often in a day, usually complete within a week1

in chronic calcific bursitis

"unusually good results" with an average of 9 injections2

### **B-DEN**

systemic muscle adenylic acid therapy

- Rottino, A.: Journal-Lancet 71:237, 1951.
- 2. Susinno, A. M., and Verdon, R. E.: J.A.M.A. 154:239 (Jan. 16) 1954.



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STERANE can't improve his gambit, help him castle or assure a checkmate...but STERANE can check asthmatic bronchospasm, dyspnea and wheezing to help your patient move about freely in almost any pastime or profession with minimum discomfort or restriction. Most potent corticoid, STERANE (prednisolone) is supplied as white, scored 5 mg. tablets (bottles of 20 and 100) and pink, scored 1 mg. tablets (bottles of 100).



PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

of farm investments for doctors is that the management of a farm takes a lot of time. The busy physician can command a much higher hourly income by practicing medicine than by managing a farm, since farm income is presently at a very low level.

Before buying a farm, the doctor should decide whether he's primarily interested in an investment that will yield maximum income and price appreciation over the years-or merely in the personal satisfaction of a "new way of life." In my observation, the financial loss from farming is often greater than the personal gain. Many other investment media offer substantially greater profit opportunities for physicians.

Howard Baker Professional Management Midwest Waterloo, Iowa

#### **Grave Question**

SIRS: A friend of mine is facing an unusual business problem. He owns a lot that adjoins a cemetery, and he'd like to put up a medical building there. But he wonders whether physicians would be reluctant to rent office space in such a location.

I don't feel competent to advise him. Can your readers throw any light on this?

M.D., Connecticut END



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salt without sodium

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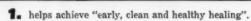
MEDICAL ECONOMICS - MAY 1957 61

#### advantages

"over other accepted local applications"

in treating wounds and burns

# DESITIN



- serves to protect the wound from mechanical and chemical injury, and from bacterial contamination.
- 3. helps check infection.
- 4. "there is no need to sterilize" Desitin Ointment.
- **5.** vitamins A and D plus unsaturated fatty acids of cod liver oil ointment stimulate healthy granulation.
- 6. it is bland, soothing, non-irritating.
- 7. healing time shortened, nursing care facilitated.

4

samples and new reprint? upon request

DESITIN CHEMICAL COMPANY

812 Branch Ave., Providence 4, R. I.

1. Grayzel, H. G., and Schapiro, S.: Western J. Surg., Obstet. & Gynec., Oct. 1956.

tubes of 1 oz...

2 oz., 4 oz., and 1 ib. jars.

#### FOLIC ACID

Primary agent in megaloblastic anemia of pregnancy and infancy, achrestic anemia and sprue. Reinforces B<sub>12</sub> in other macrocytic anemias.



#### Designed for hematinic potentiation

No wasted dosage with Pronemia — each factor is present in the specific amounts required for true hematinic potentiation. Only one capsule daily for full oral therapy in any treatable anemia. (When divided dosage of this formula is preferred prescribe Perihemin\* Hematinic, 3 capsules daily).

# **PRONEMIA**\*

Each PRONEMIA Capsule contains:

Vitamin B<sub>12</sub> with Intrinsic Factor Concentrate 1 U.S.P. Oral Unit Vitamin B<sub>12</sub> (additional) 15 megm. Powdered Stomach 200 mg. Perrous Sulfate Exsiccated 400 mg. Ascorbic Aeld (C) 150 mg.



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LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK \*REG. U, S. PAT, OFF.

#### ANNOUNCING...THE FULL

outmoding older concepts

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IN THE FULL RANGE OF AGITATED MENTAL

AND EMOTIONAL DISTURBANCES FROM SEVERE

PSYCHOSES TO ANXIETY AND TENSION STATES,

age-old methods of merely sedating the anxious or of

managing hospitalized patients by heavy sedation or physical
restraints have been largely supplanted by the older tranquilizers.

Certain of the latter agents in turn are due to be superseded by
TRILAFON, a new all-purpose tranquilizing agent which offers
greater potency combined with increased flexibility and an adequate
margin of safety in the recommended dosage ranges.

#### L L R A N G E T R A N Q U I L I Z E R

with markedly enhanced potency

# Trilafon (pronounced Tril'-a-ton) perphenazine

equally valuable in all degrees of psychic disorder responsive to tranquilizing therapy

ACITATED HOSPITALIZED PSYCHOTICS

ANXIETY AND TENSION STATES

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- · potency increased 5-fold over chlorpromazine
- uniquely high therapeutic index 10 times higher than chlorpromazine in animal studies
- jaundice notably infrequent in studies to date
- · significant hypotension virtually absent
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- · skin photosensitivity neither observed nor elicited experimentally
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#### unexcelled also as a potent antiemetic

Dosage: For specific information consult Schering literature.

Packaging: TRILAFON Tablets: 2, 4, and 8 mg., bottles of 50 and 500;
16 mg. (for hospital use), bottle of 500.

Schering

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"You say you can also mix it with flavorful orange or luscious grape juice?"

It is hard to decide which is best...

Metamucil with water, milk or fruit
juice—they combine equally well with
Metamucil. But use cool liquid for best
results. Irritant laxatives are unnecessary
with Metamucil since this hydrophilic
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stimulates normal peristalsis.

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new assurance for the aged with herpes zoster

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MAKE IT POSSIBLE

Thoroughly proved over a number of years, Gomco Circumcision Clamps permit a technique that greatly simplifies the operation on both newborn and adults. These clamps not only save time, but produce clean-cut incisions that seal in 24 hours—greatly reducing the incidence of infection. With Gomco Circumcision Clamps, no sutures are required for infants—a saving which pays for the clamps in a short time.

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g the technique used by thousands of physicians, contact your dealer or write: Gomco Circumcision Clamps are available in complete range of sizes:

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500-S	Ex. Small	1.1cm(1/6")
500	Newborn	1.3cm(1/2")
501-5	Infant	1.45cm(%")
501	Child	1.6cm(%")
502	Youth	2.1cm(18/6")
503	Adult	2.6cm(1")
504	Adult	2.9cm(11/6")
505	Adult	3.2cm(1¼"
506	Adult	3.5cm(1%")

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EVOLUTION: The primary red, scaly papules of untreated psoriasis develop by coalescence into large patches covered with thick, imbricated scales.

INVOLUTION: Under treatment with RIASOL, the patches clear up first in the center and then toward the periphery. Finally, discoloration fades leaving normal skin.

RIASOL accelerates the natural healing process by treating the deeper epidermal layers from which the cutaneous lesions of psoriasis take origin. Clinical tests show clearing of or improvement in the skin patches in 76% cases of psoriasis treated with RIASOL.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress,

Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles, at pharmacies or direct.

#### Test RIASOL Yourself



MAY WE SEND you professional literature and generous clinical package of RIASOL. No obligation.

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Dept. ME-557 12850 Mansfield Avenue Detroit 27, Michigan



BEFORE USE OF RIASOL



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RIASOL FOR PSORIASIS

#### TREAT HER MORNING SICKNESS...THE NIGHT BEFORE



#### ... In 200 cases, effective in all but one.1

Long-acting Beadectia, new anti-emetic, unusually effective in prevention of nausea and vomiting of pregnancy. Beadectin gives your patient the benefit of three distinct and complementary modes of action:

- antispasmodic relaxes G.I. smooth-muscle spasm
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- 3. nutritional supplementation to overcome possible pyridoxine deficiency of pregnancy

#### ... Relieves morning sickness "before it starts"

Other advantages include:

- 4. simple, convenient bedtime dosage
- 5. low cost to patient

## **Bendectin**

Bendectin contains in each specially

Bentyl (dicyclomine) Hydrochloride . 10 mg. Decapryn (doxylamine) Succinate . . . 10 mg. Pyridoxine Hydrochloride . . . . . . . 10 mg.

USUAL DOSAGE: 2 tablets at bedtime. SUPPLIED: Bottles of 100 tablets.

L. Nulten, R. O.: Onio State M.J. (In press).

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primary disorder, of course



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Metabolic stress hitchnikes along with every primary disorder. By simply adding VITERRA early in treatment, you combat stress by providing a comprehensive nutritional buildup program.

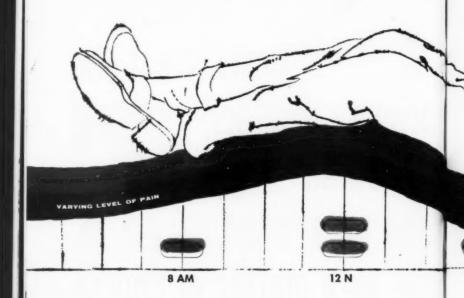
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Specify the VITERRA form which best suits your - and your patient's needs. (1) VITERRA Capsules, for daily supplementation. In bottles of 30 and 100. (2) When capsules are a problem, VITERRA TASTITABS, which can be chewed, swallowed, or mixed in liquids. Ideal for children. In bottles of 100 and 250. (3) VITERRA THERAPEUTIC, when high potencies are indicated. In bottles of 30 and 100.

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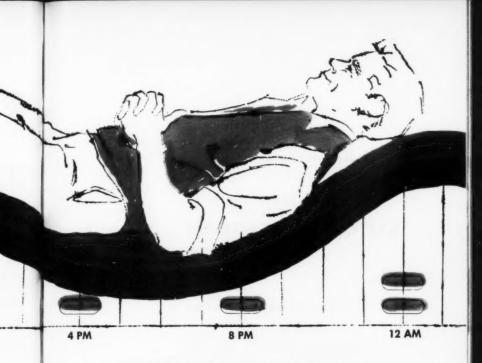
- · with the proper potency to match pain intensity
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# Phenaphen Codeine

\*except those for whom recourse to morphine is inescapable.



A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA Ethical Pharmaceuticals of Merit since 1878



Phenaphen and Phenaphen with Codeine provide a wide range of analgesia, plus complete dosage flexibility, to match varying pain requirements.

Yours to prescribe:

The right dose of the right potency at the right time.



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Basic non-narcotic formula

For mild to moderate pain

Each capsule contains:

 Acetylsalicylic acid (2½ gr.)
 162.0 mg.

 Phenacetin (3 gr.)
 194.0 mg.

 Phenobarbital (¼ gr.)
 16.2 mg.

 Hyoscyamine sulfate
 0.031 mg.

Phenaphen No. 2

Phenaphen with Codeine Phosphate 1/4 gr. (16.2 mg.)

For moderate to severe pain

#### Phenaphen No. 3

Phenaphen with Codeine Phosphate  $\frac{1}{2}$  gr. (32.4 mg.) For severe or stubborn pain

#### Phenaphen No. 4

Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

For stubborn or intense pain—to obviate or postpone use of morphine or addicting synthetic narcotics

DOSAGE: One or two capsules as required.





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'Roche'

#### For round-the-clock therapy With two doses a day

Lipo Gantrisin 'Roche'-a new, palatable liquid for antibacterial therapy-offers three significant features:

- 1. Only two doses a day needed in most cases
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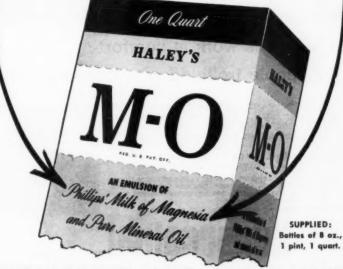
Lipo Gantrisin® Acetyl-brand of acetyl sulfisoxazole in vegetable oil emulsion

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## TO HELP CORRECT CONSTIPATION Antacid • Laxative • Lubricant

Magnesium Hydroxide plus pure mineral oil make Haley's M-O a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and the attendant gastric hyperacidity. The oil globules in Haley's M-O are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is avoided and a comfortable evacuation is effected through stimulation of normal intestinal rhythm and blunted defecation reflex.



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Supply: Nupercainal Suppositories, each containing Nupercaine base 2.5 mg., zinc oxide, bismuth subgallate, actione sodium bisulfite 0.05% (as a preservative) and cocoa butter; boxes of 12.

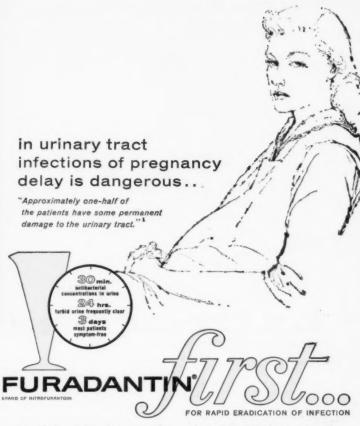
Also available: Nupercainal Ointment and Cream.



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SUMMIT, N.J.

**Suppositories** 



Specific for genitourinary tract infections · rapid bactericidal action · negligible development of bacterial resistance · nontoxic to kidneys, liver and blood-forming organs · safe for use in pregnancy2,3

AVERAGE DOSAGE: 100 mg. q.i.d. with food or milk. Continue for 3 days after urine becomes sterile.

SUPPLIED: Tablets, 50 and 100 mg. Oral Suspension (25 mg. per 5 cc. tsp.).

REFERENCES: 1. Rives, H. F.: Texas J. M. 52:224, 1956. 2. Diggs, E. S.; Prevost, E. C., and Valderas, J. G.: Am. J. Obst. 71:399, 1956. 3. MacLead, P. F., et al.: Internat. Rec. Med. 169:561, 1956.

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a new class of antimicrobials-neither antibiotics nor sulfonamides



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If he turns his back on food, the infant can neither gain weight nor grow properly.

Efficient protein synthesis requires all the essential amino acids, simultaneously, in the correct proportions.

But many foods in the infant diet are relatively deficient in lysine, compared with meat protein.

Supplied: In 46 Gm. bottles with special Lactofort measuring spoon enclosed.

Persistent anorexia calls for nutritional support with Lactofort

This complete nutritional supplement helps to restore normal growth and perk up lazy appetites in infants with anorexia and impaired nutrition. It supplies physiologic amounts of t-lysine to raise the biological value of milk and cereal to that of high-quality animal protein. In addition, Lactofort provides generous amounts of iron, calcium and all the essential vitamins.

Reference: Williamson, M. B., in Albanese, A. A., et al.: New York State J. Med. 55:3453, 1955.

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provides the emotional tranquilizer, ATARAX<sup>9</sup> (hydroxyzine) and the preferred corticoid, STERANE® (prednisolone) . control of emotional factors by tranquilization enhances response to the corticoid for greater clinical improvement • often permits substantial reductions in corticoid dosage, accompanied by reduction of hormonal side effects • confirmed by marked success in 95% of 1095 cases of varied corticoid indications

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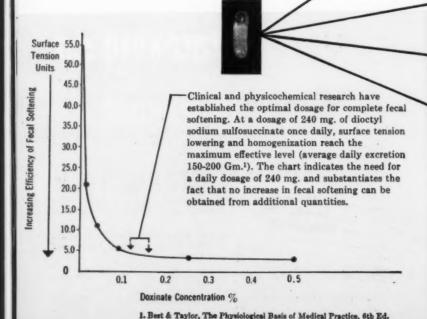
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## Views

#### Pressure on Our Schools

"The United States is headed toward an explosion in population." That's how one of our news magazines describes the current baby boom. The country's population, now 170,000,000, is expected to soar to 200,000,000 within the next ten years.

What about our doctor population? Will our medical schools' output be enough to keep up with this continuing surge of prospective new parents?

Cold statistics suggest that it will take some doing.

During the last two decades, U.S. medical schools have helped to keep the country's doctor-population ratio more or less constant. It's currently estimated to be one M.D. for every 750 people-roughly the same ratio as in 1937 and 1947. But in recent years medical school output hasn't been enough by itself to maintain this favorable ratio. The licensing of large numbers of foreign-trained physicians (more than a thousand in 1956 alone) is what's kept the ratio constant.

If this supplementary source of supply should dwindle, as it well might, the pressure would really be on our schools.

Are we prepared for this? Well, some new medical schools are getting into production. The universities of Missouri and Mississippi graduate their first four-year classes this year. And within the next three years, M.D.s will start coming out of West Virginia University, Albert Einstein (New York), Seton Hall (New Jersey), and the University of Florida. That helps.

But this still may not help enough if the licensing of foreigntrained physicians falls off. Just to keep pace with America's population boom, we may need as many as thirty new medical schools by 1975. That, at least, is the prediction of Dr. George P. Berry, dean of Harvard Medical School. And it takes a long time to start a new medical school.

Dr. Berry says the profession

ought to be picking its spots right now. And he's right. Pressure on the schools can easily turn into pressure on the whole profession. If doctors want to stave it off, now's the time for them to start planning wew sources of new M.D.s.

#### 'Those Damned Dues'

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Remember the hubbub that arose a few years ago when the A.M.A. began charging annual dues? The amount was only \$25; but since it came on top of local and state medical society levies, it set a good many doctors to grumbling.

The grumbling still persists in some quarters. So, just for fun, we recently did a small survey to see how doctors' dues compare. We picked a dozen different professions or trades in a dozen different cities; and we found out what members pay annually in local, state, and national dues to their professional or union organizations.

In general, we found, doctors' dues run higher than most others

—but not much higher. In a few places, they run lower. Some sample findings:

¶Doctors' dues average about \$100 in the cities surveyed. (That's the average of their total dues to local, state, and national medical societies.) The comparable figure for airline pilots is over \$200; for architects, about \$90; for accountants, about \$70; for lawyers, about \$60; for steel workers, \$60.

¶In Baltimore, the doctors pay a total of \$70 in annual dues—but the architects pay \$77.50.

¶In Chicago, the doctors pay \$80 in dues—but the lawyers pay \$117.

¶In Newark, N.J., the doctors pay \$75 in dues—but the architects pay \$95, and the bricklayers, masons, and plasterers pay roughly \$100 (their dues are set at 5 cents per hour worked).

¶In New York, the doctors pay \$75 in dues—but the accountants pay \$80, the architects \$85, and the lawyers \$106.

We didn't set out to prove any-

otentiate

VIEWS

thing with this small sampling. But as independent observers, we're forced to conclude that "those damned dues," as they're so often called, are the normal price paid not only by doctors but by most other highly skilled workers in today's highly organized society. And if doctors pay more than most others-well, the signs are that they get more, too.

#### Clinic Courtesy

Many a private practitioner who devotes time to dispensary or clinic work treats clinic patients with the same courtesy and finesse, he gives his private patients. But there are a few notable exceptions to the rule.

You may, for instance, have seen a clinic doctor skip all conversational pleasantries. Or disregard some of the niceties in applying dressings, local anesthetics, and such. Or use the patient's first name in an amiable but patronizing manner, when he'd never even dream of doing so in his own private practice.

If he thinks of it, a physician will conduct himself in a clinic just as he does in his own office. Apart from the simple humanity involved, it keeps him in the habit of treating all patients graciouslyan obvious asset to any physician. Since the clinic patient of today is often the private patient of tomorrow, uniform courteousness is also a potential practice-builder. Finally,

external eye conditions consistently respond to...

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(prednisolone acetate and sulfacetamide sodium)

Ointment with Neomycin

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blepharitis "responded dramatically to both the drop and ointment form of therapy":

allergic conjunctivitis "cleared almost completely

in 48 hours in 12 of 14 cases?

38 of 42 cases "subsided within four to seven days...."

episcleritis "responded successfully to topical Metimyd..."

marginal ulcers "completely cleared in 24 hours"

Abrahamson, I. A., Jr., and Abrahamson, I. A., Sr.: Am. J. Ophth. 42, 482, 1986.

METIMYD," brand of prednisolone acetate and sulfacetamide sodium

WW- 1117

1

the considerate manner helps nail the lie that poor people get shabby treatment.

The average physician devotes from 8 to 24 per cent of his time (depending on general economic conditions) to free medical service. With almost no extra effort, he can nevertheless make those extra hours count.

#### When to Say No

You won't hear this from many insurance agents, but it's a fact: Quite a few older physicians today are carrying more life insurance than they need.

The prime purpose of life insur-

ance, after all, is to replace the economic value of your life to your dependents. This calls for lots of insurance-sometimes all you can manage to carry-through your middle years. But what about after

Have your children become selfsupporting? Is your house finally paid for? Have you reached the last decade of your productive career? In any of these circumstances, what you are likely to need is less life insurance, not more.

Yet too few doctors reduce their insurance coverage when they reach these milestones. Some, under pressure from patients who sell insurance, even buy more. This re-

## for Nausea and Vomiting

ALWAYS

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FIRST

Highly effective when condition is functional; will not mask organic derangement; safe physiologic action . . . no drug side effects

proved in: epidemic vomiting, functional nausea children, 1 or 2 tsp.; adults, 1 or 2 tbsp.; repeat every 15 minutes until vomiting ceases.

proved in:

"morning sickness" - 1 or 2 thsp. on arising; repeat in three hours and whenever nausea threatens.

In bottles of 3 fl.oz. and 16 fl.oz. DO NOT DILUTE

KINNEY & COMPANY, INC. COLUMBUS, INDIANA



sults in stiff premium commitments that can keep an older practitioner from slowing down and enjoying life.

Sure, you want to build up an estate. But the chief use of life insurance is to protect your dependents in the event of your death. And they need less protection of this sort as you move over to the shady side of 55.

#### Telephone Trap

The phone rings late at night. The voice on the wire says: "My little boy has a bad earache, Doctor. Will you order something from the drugstore to relieve the pain?"

Perhaps you've been tempted by come-ons like this. Perhaps you've thought about taking the easy way out: phoning the druggist, having him deliver a prescription, and not seeing the patient yourself until morning.

"Don't do it!"

That's the heartfelt advice of a California G.P. who was confronted with just such a situation. He tried to handle it by phone-and narrowly missed a malpractice rap. Here's what happened.

Two hours after the first phone call, the boy's father called again: "The ear is worse, Doctor. Can we meet you at the office right away?"

When the pair arrived, it soon





Psoriasis of 5 years duration



Skin cleared after only 7 weeks

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With MAZON soap, the treatment of choice for Eczema, Alopecia and other skin conditions not caused by or associated with metabolic disturbances.

Dispensed only in the original blue

Belmont Laboratories. Philadelphia, Pa.

#### VIEWS

became clear why the ear was worse. The doctor had ordered a sedative suppository and some eardrops; the former had been stuffed into the ailing ear, the latter laboriously inserted into the rectum.

"I spent a tedious half hour digging the melted suppository out of the external ear canal," the physician reports. "And all the while I kept thinking: You can't practice medicine without a telephone. It's equally true that, in many cases. you can't practice medicine with a telephone."

#### Fees vs. Values

A sense of values is a fragile thing. It can be shattered by a stranger's casual remark. Even if the remark is delivered in a listless monotone. devoid of all emotion.

A Washington cab driver was doing the talking: "I worked eleven hours yesterday," he said as we threaded our way through traffic. "I went home with \$10 in my pocket and a splitting headache. So I phoned the doctor. He said he could stop in and see me on his way to the hospital-it wouldn't be any trouble. Well, he stayed just ten minutes, wrote me out a prescription, and charged me \$7-cash. How about that?"

It's a good thing, now and then. to have our sense of values shattered. The pieces can always be put back together, cemented in place with just a bit more human understanding. END



#### invitation to asthma?

#### not necessarily . . .

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Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes... Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation. for 4 full hours... Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

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Theophylline												2	gr.
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Proctologic



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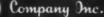




Pediatric-Child



Lateral (Sims)



RITTER PARK . ROCHESTER 3, N. Y.



of E. coli and Candida albic the bacteria, but not the mor Nystatin combined (center) e ring). Nystatin (right) elimina

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#### culture

Phosphate (left) eliminates ns). Panmycin Phosphate and e bacteria and monilia (clear , but not the bacteria (haze).

## COMYCIN

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#### Each capsule contains:

Tetracycline phosphate complex equivalent to tetracycline hydrochloride, 250 mg.; Nystatin, 250,000 units. Indications and desage:

Same as for tetracycline HCI.

Supplied:

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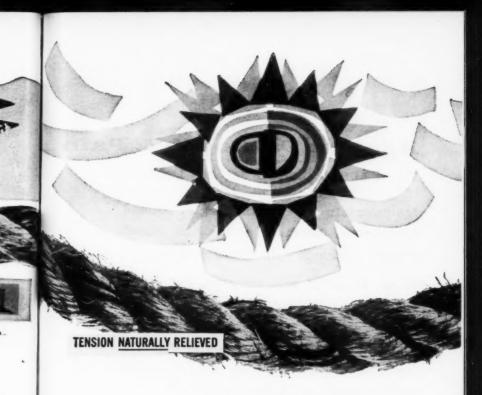


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Consistently effective control of visceral spasm and hypermotility of smooth muscle is assured by Donnatal through its three natural belladonna alkaloids, plus phenobarbital. Judiciously balanced for optimal synergism, they have been found superior to atropine alone in range of action-and more dependable and less toxic than the synthetic preparations.2 "Excellent results" in "a wide range" of gastrointestinal disturbances.1

1. Marks, L.: In press.

2. Morrissey, J. H.: J. Urol. 57:635, 1947.

•in proven optimal ratio:

Phenobarbital

each Tablet Extentab Capsule (Extended Elixir (5 cc.) action tablet) Hyoscyamine sulfate 0.1037 mg. 0.3111 mg. Atropine sulfate 0.0194 mg. 0.0582 mg. Hyoscine hydrobromide 0.0065 mg. 0.0195 mg.

16.2 mg. (¼ gr.) 48.6 mg. (¾ gr.)

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#### Against Pathogen & Pain

in urinary tract infections

Azo Gantrisin combines the single, soluble sulfonamide, Gantrisin, with a time-tested urinary analysis - in a single tablet.

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safe3...and non-constipating1-3

The multiple adsorbent and ion-exchange materials in Resion are "totally insoluble and non-toxic." No cases of constipation reported in three clinical series of more than 250 patients.  $^{1-3}$ 

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Dosage: RESION...... 1 tablespoonful hourly for 4 doses; then every three hours while awake.

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—the same schedule as above, but in teaspoonful doses.

Supplied: Resion is supplied in bottles of 4 and 12 fluid ounces; Resion P-M-S in bottles of 4 fluid ounces.

REFERENCES: 1. Weiss, J.: K.A.G.P. Journal 2:33, 1956. 2. Gabroy, H. K., and Selaman, G. J. V.: Amer. J. Dis. 20:395, 1953. 3. Lichtman, A. L.: Exper. Med. & Surg. 9:90, 1951.

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# SELECTIVITY for treatment of hypersecretion and hypermotility IN PEPTIC ULCER





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integrated relief ... mild sedation visceral spasmolysis mucosal analgesia

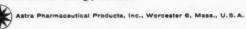
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Today, a new type of Laundry Store—THE COIN-OPERATED COMPLETELY UNATTENDED WESTINGHOUSE LAUNDROMAT-is springing up all over America. Originating in Texas less than two years ago, these automatic self-service laundry stores have spread through Florida, California . . . and are now being chain-operated in Illinois and Missouri.

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- Many women prefer to do their own laundry. We don't know why, but it's a fact . . . 5

  Machine service and daily maintenance is contracted out to your local repairman and local porter. You visit the store only to collect the coins.
- 2 Laundry is a necessity and people, especially in the lower income groups, will walk 3 or 4 extra blocks to SAVE ALMOST 50% on their weekly laundry bill.
- 3 Bachelors, career girls, students and working families can only do laundry during hours when regular laundry stores are closed . AN UNATTENDED LAUNDRY IS OFTEN OPEN 24 HOURS A DAY, 7 DAYS A WEEK. Profits are realized in night and weekend hours when other laundries are closed.

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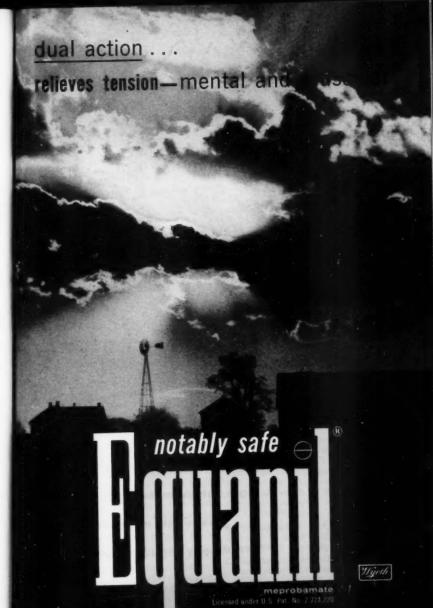
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single sulfonamide exhibiting
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at radically reduced dosage

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LOW DOSAGE: a total maintenance dose of only 2 tablets daily.

**SOLUBILITY:** prompt absorption, ready diffusion into body fluid and tissue.

PROLONGED ACTION: therapeutic blood levels within the hour, blood concentration peaks within 2 hours—5-10 mg. per cent blood levels persist 24 hours after a single oral dose of 1 Gm.

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safety based on low required dosage, solubility, slow excretion rate. Although KYNEX Sulfamethoxypyridazine is a sulfonamide derivative and the usual precautions regarding such drugs should be observed, the low daily dose of 1.0 Gm. is all that is required for therapeutic blood levels. No increase in dosage is recommended.

**CONVENIENCE:** The low adult dose of 1 Gm. (2 tablets) per day offers optimal convenience and acceptance to patients.

TABLETS: Each contains 0.5 Gm. (7½ grains) sulfamethoxypyridazine. Bottles of 24 and 100.

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MEDICAL ECONOMICS · MAY 1957 109

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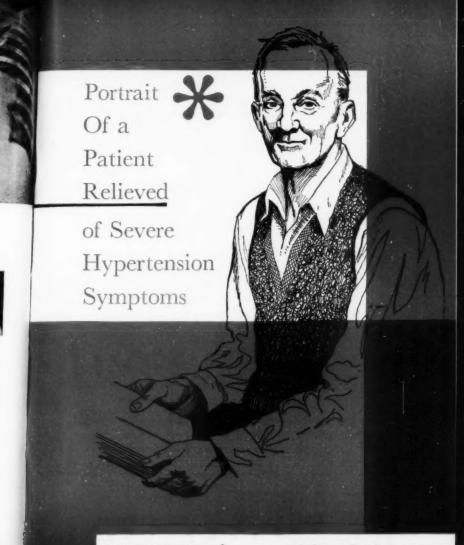
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SIGNIFICANT: Wilkins, R. W.: Mississippi Doctor 30:359, 1953. Wilkins, R.W., and Judson, W. E.: New England Jrl. of Medicine 248:48, 1953. Duncan, Garfield G.: Philadelphia Medicine 51:24, 1956.

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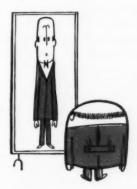


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### **Medical Economics**

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, MAY, 1957 . VOL. 34, NO. 5



### How the Specialties Compare Financially

By Wallace Croatman

Despite talk about the resurgence of the G.P., medicine is becoming more and more a world of specialists. In 1950 only 37 per cent of U.S. physicians were full-time specialists; by 1956 the figure had climbed to 44 per cent.

Specialists thus constitute a larger part of the medical profession today than at any time in the past. What's more, today's typical full-time specialist is faring better financially than ever before. His net income from practice

in 1955 (\$18,010) was almost one-fifth greater than in 1951. And he earned this higher income while seeing fewer patients than he did four years earlier.

Who is this "typical" specialist? He's a man of many talents and paradoxes-a composite of practitioners in at least thirty branches of medicine, each with its own characteristics.

On the one hand he's a radiologist/roentgenologist, seeing twenty-six patients a day; on the other he's a pathologist, seeing only three patients a day. He's one-fifth internist, one-twelfth pediatrician. He's five kinds of surgeon—and an obstetrician too.

In this highly specialized age, a man like that doesn't really exist. So this article will not concentrate on the typical specialist. Rather, it will deal with the typical man in each specialty. Specifically, it will discuss the distinguishing economic facts about each of the twelve numericallylargest specialties as well as some of the "minor" specialties.

The information comes primarily from MEDICAL ECONOMics' 1956 Quadrennial Survey.

#### Anesthesiology

The most distinctive economic

fact about the anesthesiologist is that he spends only \$3,400 a year on professional expenses. That's just 14 per cent of his gross income. His expenses are lower than those of any other specialist except the man in full-time industrial practice. They're only onefourth as high as those of the plastic surgeon, the specialist with the highest costs.

Unfortunately for the anesthesiologist, his gross income is also the lowest of any major specialty. So his net earnings, despite the favorable expense figure, are only slightly above the all-specialties median. His hourly net income is quite low; in fact, at \$6.68 an hour, he's one of three typical men in the major specialties to net less than \$7.

The anesthesiologist sees only eight patients a day, fewer than any other specialist except the pathologist. Because anesthesiologists' practices are so hospitaloriented, most of them (51 per cent) get along without personally employing a full-time aide.

#### Ear, Nose, Throat

Although the ENT man earned more in 1955 than he did four years before that, his relative position among the major specialties has declined. Between 1951 and 1955, he dropped from fifth to tenth place on the net-income ladder.

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The typical ENT man sees an average of twenty-five patients a day, or five more than the normal specialist case-load. His expenses are well above average; almost \$12,000 a year. In most other respects he ranks near the middle of the specialties. He nets \$18,-000 a year; he collects 90 per cent of his accounts; and his estate is valued at \$90,000.

Specialists in this field, together with those in EENT, are on the average about five years older than specialists in general. The typical ENT or EENT man is in his early fifties. From 1949 to 1956, a period in which almost all specialties scored heavy numerical gains, the number of ENT/EENT men in the U.S. actually declined 12 per cent.

#### Eye, Ear, Nose, Throat

The EENT man has much in common with the ENT specialist; but he's also an economic personality in his own right. His expenses (\$12,033) are higher than those in any other major specialty except orthopedic surgery. He puts a higher percentage of his gross income into expenses (39 per cent) than does anyone else in the dozen largest specialties.

Part of this high-expense factor is explained by the fact that fully 95 per cent of the EENT men surveyed employ one or more aides. This figure is topped in only two others of the dozen major specialties.

Although his \$19,000 net income for 1955 was only slightly above the all-specialties median, the EENT man netted \$8.01 an hour. That's fourth highest among the twelve large specialties and 18 per cent above his hourly net for 1951.

#### **General Surgery**

Surgery today is an old specialty practiced by young men: The typical surgeon is about 43, five years younger than specialists in general. Except for internal medicine, surgery is the largest specialty numerically. It's also the major specialty with the smallest proportion of board-certified men (only 48 per cent).

The surgeon has grounds for reappraisal of his income these days. It's true that his 1955 net income (just under \$19,000) was higher than the all-specialties

#### HOW THE SPECIALTIES COMPARE

median; it was also 10 per cent higher than his own income in 1951. Relatively, though, the surgeon's income gains are lagging behind those reported in most other fields.

In 1951 he and the ob./gyn. man were the major specialists with the highest incomes. The latest figures show the surgeon's

earnings no higher than eighth among those of the dozen large specialties.

His 1955 hourly net (\$7.05) was almost exactly the same as in 1951. He's the only man in a major specialty whose hourly net income failed to rise in that fouryear period:

One encouraging trend: His



"Here's one that looks interesting: 'Will Hitler Really Invade Poland?" "

collection percentage, once among the lowest, has reached a respectable 90 per cent. And the surgeon still benefits more than most M.D.s from health-insurance payments. Last year he got three-tenths of his gross income from this source—a higher proportion than that of any other specialist except the thoracic surgeon.

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#### Internal Medicine

The internist netted only \$14,-350 in 1955—less than the typical G.P., less than all but three other specialists out of thirty, and 20 per cent less than the median for all specialists. But this was nothing new. Internal medicine has been one of the poorest-paying specialties for years. And today's internist can note at least a few signs of improvement. His hourly net income (\$5.48 in 1955), while still among the lowest reported, was 17 per cent higher than in 1951.

Low earnings notwithstanding, there are more doctors in internal medicine than in any other specialty—one out of every five specialists, at last count. Which may set the internist to wondering: Are earnings in this field low because there are too

many internists? Or are there enough other compensations here to lure doctors in spite of the financial discouragements?

#### Obstetrics/Gynecology

With a pardonable fondness for round figures, the median ob./gyn. man reports his 1955 net earnings at \$20,000. Although this is close to a 20-percent gain in four years, his relative position actually declined during this period. From a tie for top position, he dropped to fifth place among the major specialties.

Surprisingly, his income is about 20 per cent *lower* in the West than for the country as a whole. Most specialists do better financially in the West than in any other region.

Like the general surgeon, the ob./gyn. man has improved his collection percentage recently. Tenth among the twelve largest specialties five years ago, he collected 90 per cent of what patients owed him last year. None of the major specialists did better than that.

#### Ophthalmology

The eye specialist has a right to be pleased nowadays. His

1955 net income (\$20,100) was some 30 per cent higher than it was four years earlier. He thus climbed from sixth to fourth place on the large specialties' income ladder.

The ophthalmologist worked an average of only 45 hours a week last year, fewer than any other major specialist. His hourly gross income (\$14.87) was second-highest among the twelve major specialties. Although his expenses (\$11,000) were above average, his hourly net was an impressive \$9.16. That's \$2 an hour above the all-specialties median.

The fact that 92 per cent of today's full-time ophthalmologists are board-certified may have something to do with this specialty's increasingly favorable earnings picture.

#### **Orthopedic Surgery**

The orthopedist's 1955 net income (\$24,967) was the highest of any of the twelve major specialties. It was third highest among all thirty fields, 40 per cent above the all-specialties median. This represented a big improvement for the orthopedist, who was only fourth among the twelvelargest specialties, in terms of income, back in 1951.

Matching the favorable earnings trend is the growing popularity of orthopedic surgery as a specialty. Although orthopedists rank only ninth among the specialties numerically, they've shown a 46 per cent growth since 1949.

Accompanying the earnings and growth factors are a few less favorable ones. The orthopedist was only seventh among the twelve large specialties in 1955 hourly net income. His expenses (\$12,050) were topped by only three out of the thirty specialties.

The orthopedic surgeon is more likely to have an aide than is any other specialist; 97 per cent of the men in this field employ one or more aides. As of a year ago, the orthopedist was more strongly opposed to compulsory Social Security coverage for physicians than any other specialist; only one orthopedist in three favored it.

#### **Pediatrics**

A recent MEDICAL ECONOMICS survey of job satisfaction in the major types of practice showed the pediatrician to be less satisfied with his field than any other physician. It's not hard to see

some reasons why this is true.

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For his 60-hour week, the pediatrician netted less than \$15,-000 in 1955. Income-wise, he was next to last among the twelve large specialties. On an hour-forhour basis, he was last. His hourly gross was \$7.91; his hourly net, \$4.99. His earnings have gone up only slightly since 1951.

For all this, though, there must be strong attractions to the field. Pediatrics is growing faster than any other large specialty. It's had a 47 per cent increase in numbers since 1949.

#### **Psychiatry**

Economically as well as clinically, psychiatry seems set apart from the other specialties.

The psychiatrist's 1955 expenses (\$6,500) were lower than those of all but five of the thirty specialties. Unlike most other specialists, the psychiatrist generally does not have a full-time aide (only 36 per cent of the psychiatrists surveyed employ one or more aides). The typical man in this field also carried relatively little malpractice insurance (\$25,000/\$75,000).

The psychiatrist sees an average of only nine patients a day. He works a relatively short 50hour week. He derives virtually no income from health plans. And he has a 95 per cent collection ratio—second-best among the thirty specialties.

Although his net income has recently been below the all-specialties median, the psychiatrist evidently profits by experience: He's the only man in a major specialty to reach his income peak after twenty-five years in practice.

Lately he's also been doing considerably better than in the past. His hourly net earnings, though still fairly low in comparison with those of other fields, were 34 per cent higher in 1955 than in 1951.

Eighty-five per cent of the psychiatrists surveyed by MEDICAL ECONOMICS said that they were happy with their choice of specialty. This was a higher percentage of satisfaction than in any other field. Yet psychiatrists seemed less than satisfied with their current level of economic security (the typical psychiatrist's estate in 1955 was valued at a relatively low \$75,000). Incidentally, while the rest of the profession came out more or less solidly against compulsory Social Security coverage for private

#### HOW THE SPECIALTIES COMPARE

physicians, 64 per cent of the psychiatrists wanted it.

#### Radiology/Roentgenology

In terms of net income, the radiologist/roentgenologist a year ago ranked third in the field of twelve big specialties-the same as in 1951. His hourly gross and net earnings, though, were higher than those in any other major specialty. His \$9.74-anhour net represented a 30 per cent hike in four years.

#### **Key Figures on the Twelve**

Specialty	Net Earnings	Professional Expenses	As % Of Gross
Anesthesiology	\$19,050	\$ 3,400	14%
Ear, Nose, Throat	18,000	11,975	35
Eye, Ear, Nose, Throat	19,000	12,033	39
General Surgery	18,975	9,005	32
Internal Medicine	14,350	8,985	37
Obstetrics/gynecology	20,000	9,225	31
Ophthalmology	20,100	11,000	33
Orthopedic Surgery	24,967	12,050	33
Pediatrics	14,992	8,033	34
Psychiatry	17,300	6,500	26
Radiology/roentgenology	20,850	12,033	31
Urology	22,000	10,975	32
All Specialties	18,010	9,150	33

<sup>\*1956</sup> figures. All other figures are 1955 medians for self-employed M.D.s

The radiologist/roentgenologist had high expenses (\$12,033), but this figure amounted to only 31 per cent of his 1955 gross income. Malpractice insurance was a relatively big item for him; he carried \$100,000/\$300,000 pro-

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tection. Moreover, at last count, 96 per cent of the men in this field employed one or more fulltime aides.

Two other items of interest: The radiologist/roentgenologist recently reported that he sees an

#### Largest Medical Specialties

Hourly Gross Earnings	Hourly Net Earnings	Patients Seen Daily*	Hours in Practice Weekly*	% of Gross From Health Plans*	Collection Percentage	
\$ 7.96	\$6.68	8	54	20%	90%	\$100,000
12.44	7.75	25	50	20	90	90,000
13.78	8.01	25	50	10	90	100,000
10.78	7.05	15	60	30	90	100,000
8.95	5.48	17	60	5	90	75,000
10.89	7.29	20	60	20	90	100,000
14.87	9.16	20	45	6	90	98,000
12.47	7.87	20	60	20	90	100,000
7.91	4.99	20	60	3	90	85,000
10.16	7.17	9	50	0	95	75,000
15.72	9.74	26	50	12	90	100,000
12.39	8.00	20	60	23	90	100,000
11.12	7.10	20	55	10	90	90,000

(those who get more than half their net incomes from fees for service).

1

average of twenty-six patients a day, the heaviest patient load of all specialties. And 98 per cent of the men in this field are boardcertified—the highest percentage in any major specialty.

#### Urology

In 1951 the urologist was seventh among twelve large specialties in net earnings. Four years later he'd jumped to second place. His \$22,000 net in 1955 was topped only by the orthopedic surgeon's. Moreover, the urologist's 1955 hourly net income (\$8.00) was nearly a third above what it was in 1951—the biggest increase to show up in any major specialty.

Last year the urologist got about a quarter of his gross income from health plans, a higher proportion than in any other major specialty except surgery. Part of his strong income showing may be due to his above-average experience. His age (53) is about five years higher than the median for specialists in general.

All told, the specialties described above account for about 85 per cent of the total specialist population. When all specialties, major and minor, are compared,

a few other distinctions come to light.

One of the least typical specialties, certainly, is industrial medicine. The typical industrial M.D. recently ranked first among thirty fields in collections (99 per cent). But this may have been less a reflection of his own efficiency than of the dependability of business accounting departments and of his salaried or semi-salaried status.

The industrial doctor is last in a few respects in which it's nice to be last: He has the lowest expenses (\$2,000 in 1955) and the shortest work week (40 hours). Offsetting these easy-totake figures is the fact that his 1955 net income was a modest \$13,017. Only the pulmonary specialist earned less.

At the other end of the income scale is the specialist who limits his work to radiology. His 1955 net was \$25,040, a few dollars more than that of the neurosurgeon.

The latter—who had the highest net income of any specialist in 1951—can point to one big reason for his continued good showing: His 66-hour work week is longer than any other doctor's, including the G.P.'s.



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### How to Hedge When The Market's on Edge

Three ways to protect your capital from a really sharp drop in common stock prices

By Thomas Owens

What's the wisest course for investors when faced with an uncertain and edgy stock market? That's the question all investors—tyro and professional alike—were mulling over during the early months of 1957. Here's what had them worried:

The present bull market started in 1949. In April, 1956, it reached an all-time high: The Dow-Jones industrial average hit 521, far above the 1929 high-water mark of 381. Through the summer the average fluctuated. Then, after an August high of 520, it began to drift downward. By this April 15 it had sunk to 486.

Despite the decline, there was no unanimity of opinion on the outlook for the rest of 1957. Optimists predicted the average would climb at least back to last year's peak. Pessimists warned of a drop to the 400 level. Moderates believed it would fluctuate within a 460-480 trading range.

In the face of such conflicting predictions, many a doc-

tor-investor decided he'd do well to consult his investment adviser about the wisdom of shifting some of his commonstock money into defensive securities—investments that offer a hedge against a major drop in prices.

You may have already taken such a step. If not, you'll probably find your counselor suggesting any of the three following moves for at least part of your funds:

1. Buy bonds. This is a classic defensive move. The reason is simple: Though stock prices and stock dividends may decline substantially, a bond will pay you fixed annual interest; and it'll return all your original capital at maturity.

#### Price Could Drop

This doesn't mean that a bond investment is entirely without risk. Any bond—apart from the low-interest, fixed-price U.S. Savings Bond—can either rise or drop in price after you buy it. So if you were ever forced to dispose of a bond before maturity, you might have to sell it for less than you paid for it.

On the other hand, though, this very price flexibility is usual-

ly considered one good reason for buying such variable-price market bonds (issued by the Government, by corporations, by municipalities, etc.). In recent months, their prices have been about the lowest since the Thirties. Investors found some issues with a \$1,000 maturity value selling on the market for \$800. Anyone buying in at that price would get not only a guaranteed interest return but a \$200 profit when you cashed in the bond at maturity.

One kind of bond you may want to consider is a convertible debenture. Since such bonds-can be turned back to the issuing company at any time in exchange for shares of common stock, they offer a unique hedging opportunity. As long as the stock is low, you can hold the bond and collect the guaranteed interest. But if the stock goes up, the bond's convertible feature gives you a chance to share in the common stock's prosperity too.<sup>2</sup>

<sup>1</sup>The proportion of your total investment that should be in defensive securities depends on your objectives. A young doctor, for example, may be willing to expose his capital to greater risk, while awaiting the next boom, than an older man who'll soon need his nest egg for retirement.

<sup>2</sup>For a detailed discussion of how this conversion feature works, see "Convertible Debentures: Are They for You?" MEDICAL ECONOMICS, November, 1955.

For the doctor in a very high tax bracket, there are special advantages in tax-exempt bonds. These are issued by states, cities, highway authorities, etc. The interest they pay, though not high, is exempt from Federal income tax.

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2. Buy preferred stock. On these shares, the issuing company agrees to pay a fixed dividend each year before any dividends are distributed on the common stock. As a result, preferred-stock dividends may continue undiminished even during a sharp recession.

And as long as dividends stay constant, the share price usually holds up, too.

3. Buy the common stock of utility companies. Ambitious investors are apt to regard this as a drab, unpromising investment whenever a bull market's rolling along. But in an edgy market, the utility shares become very popular.

Glance at a chart showing the Dow-Jones utilities average, and you'll notice that the average was creeping up steadily through the winter. From 65 in October it moved up to 72 by April 15. The reason: More and more cautious money left the more speculative

stocks and sought safety in the utilities.

Such stocks generally offer regular dividends and a relatively stable price in spite of depressions and recessions. In fact, they may be even more prosperous during deflation—at any rate, during the early stages of it.

In the 1949 stock sell-off, for example, utilities reported gross revenue up only 7 per cent from the previous year, but net earnings up 16 per cent. This advantage results from the fact that utility operating costs decline during a recession, while utility rates remain relatively fixed.

#### What's Best for You?

The three hedging moves I've described are among the more popular ones with investors. They're by no means the only ones. Your own investment counselor may recommend others that he feels are better suited to your special situation.

But remember that no action he suggests can eliminate all danger to your invested savings. The most that any hedging action can promise is that you'll be less exposed to a major loss of capital if a full-scale bear market should set in.



### Rx for a Freer Life: Get a Partner!

Can a doctor be a good family man and still meet his obligations to patients? This G.P. says yes

By Irving L. Breakstone, M.D.

Right now, I'm not practicing medicine. My interest in psychiatry has caused me to take a residency in that specialty in Chicago. But a few years ago, I was a busy general practitioner. So busy, in fact, that I had no time for anything but medicine.

It was only through partnership practice that I found out medicine can be personally rewarding as well as professionally so. The story of how a partnership freed me from overwork—the curse of so many doctors today—may offer some hope to those who still function as solo practitioners.

THIS ARTICLE has won one of the 1956 MEDICAL ECONOMICS Awards. Its author was formerly senior partner of the Antioch (Ill.) Clinic.

It was on Christmas Eve, 1951, that my wife and I decided we'd just about had it. Pressure of work had left me absolutely no time to help her plan for Christmas. Or to shop for presents for our children. Or to do any of the other things that contribute to family enjoyment of the holiday season.

Shortly after the first of the year, I decided that my practice would no longer run me; I would run it. But how? I needed to think things out; so I told my aide to refer my patients to other doctors and put my practice on ice, so to speak, for three months. Meanwhile, I helped my wife pack, closed my home, and took off for Miami Beach, Florida.

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We both enjoyed relaxing under the warm Southern sun. I spent part of our vacation improving my know-how as a resident in surgery at a hospital in Miami Beach. Those three months showed me beyond any doubt what I had been missing by burying myself in my practice and neglecting my family.

By the time we went back to Antioch—a small town in a farming and resort area in northeast Illinois—I had figured out a new and entirely different mode of life and work.

My old patients soon found me. New ones came too. But this time I hired a second office girl, cut my office hours, limited the number of appointments I would make, took coffee breaks, refused obstetrical cases, and even

turned down urgent home calls.

Strangely enough, my income increased. But not so my opinion of myself, either as a doctor or as a man. Though I had more time to live with my family, I couldn't live with myself.

Sure, I could use the telephone to prescribe aspirin for a feverish child and tell the mother to bring the youngster to me in the morning. But what of the anxiety of the child's parents during the rest of the night? And what of my responsibility to other loyal patients—patients I was now either refusing to see or was referring to colleagues for procedures I'd handled for them in the recent past?

#### 'I Was Miserable'

My feeling of irresponsibility soon made me miserable. Yet I definitely didn't want to return to my old way of practicing. Then, unexpectedly, a happy solution was almost forced on me. Illness of a relative took me out of town for ten days. While I was away, I finally realized what I had to do: I had to share my practice.

I thought hard about what type of association would be best, and decided on a small partnership. (In anything larger than a two- or three-man partnership, I felt, the personal relationship between patient and doctor might suffer.)

My mind made up, I placed several advertisements, and they soon brought me several responses. But on personally interviewing the respondents, I found them too avid for money.

#### A Lucky Break

Happily then, I got another lucky break: A patient of mine told me about her son, Jim Kopriva. He'd spent his summers in Antioch years before but was now building a busy general practice in Chicago, some fifty miles away. Perhaps, she indicated, he'd like to form a partnership with me.

I wrote to him. And he said he wasn't interested. But as a courtesy to his mother, he visited me.

It was plain from his remarks that he heartily disliked city life, that he didn't want to bring up his children in Chicago, and that he was getting in the same rut in which I'd found myself. His practice was beginning to run him, instead of vice-versa.

A couple of weeks later, he returned with [MORE ON 276]

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### 'Halfway' Health Plans Aren't Enough!

People look to health insurance to cover nearly all their medical expenses. They've found that it covers far less than half, says this writer

By George Bugbee

The question that more and more people are asking about health insurance these days is: "What percentage of my doctor bills will it pay?" And by "doctor bills" they mean all medical expenses, including hospital, home nursing, appliance, and drug costs.

In today's credit economy, this question has become of crucial importance. American families are earning more than ever; but their earnings are mostly earmarked for fixed expenses, including installment payments.

They're prepared to earmark money for health insurance, too, and most of them do. But they're not prepared to pay substantial unexpected medical bills that their health insurance doesn't cover.

So what most people want is the privilege of arranging regular monthly payments that will insure them against

THE AUTHOR, a former executive director of the American Hospital Association, now heads the Health Information Foundation.

#### 'HALFWAY' HEALTH PLANS

virtually all family health expenses-from \$20 for a series of office visits to \$3,000 for a longterm hospital stay. That's the only way they can fit medical costs into their spending pattern.

That pattern was memorably portrayed in a Fortune magazine

study some months ago. Even the young executives and their wives whom the magazine had surveyed were almost uniformly caught in installment-plan living. They wanted to be "committed to regular, unvarying payments on all the major items." And they were willing to go to almost any lengths for the privilege of fixed payments. They were willing to stay continuously in debt to installment-plan merchants-and to pay a whopping average of 19 per cent interest on that debt.

Today's Americans, Fortune concluded, are determined "to gear all expenditure" to the regular monthly payment.

But that's what they can't do in the realm of medical care. The health insurance of the average insured family currently pays only about 25 per cent of the family's annual medical expenses.



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The other 75 per cent must be paid for outside the budget. And the average family finds this increasingly difficult to do.

So if the health plans want to meet public need, they must move much faster in the direction of more comprehensive coverage.

In the past, insurance men and doctors have raised four major objections to the idea of virtually complete coverage. Let me discuss these objections in their order of importance:

1. "Comprehensive coverage is wrong in principle. The purpose

> of health insurance isn't to prepay all medical costs; it's to protect people from the financial inroads of major illnessfrom the big, unexpected expenses."

> Most patients believe that the purpose of health insurance is to prepay the great bulk of their medical bills. They know it's not always illness in the hospital that breaks the budget.

> The Health Information Foundation recently studied several hundred families whose annual health expenses were running high (\$200 or more). Where was their money going? More



#### 'HALFWAY' HEALTH PLANS

than half of it went for the outof-hospital services that insurance doesn't usually cover. It may be less dramatic to shell out \$200 for medical services in a doctor's office, plus drugs, than for an operation. But the bill for medical treatment cuts just as big a hole in the budget as does the one for surgery.

2. "Comprehensive coverage is wide open to abuse. If insurance covered home and office calls, patients would call the doctor for every case of sniffles."

Actually, in a few areas where such coverage is now available, abuses are a minor problem. Very few persons rush to a doctor just for the fun of it-even when they don't have to pay.

It's true that wherever you introduce more comprehensive prepaid medical care, people begin



to see their doctors more often. But this isn't generally abuse. It's the legitimate use people ought to be making of medical personnel and facilities.

3. "Comprehensive coverage means lots of small, costly claims. It's bad policy to insure against a frequent \$5 item when it costs so much to process the claim. That's why automobile insurance usually has a \$50 or \$100 deductible feature."

I question that the cost of insuring against small claims is as great as most insurance people believe. Moreover, as Dr. Richard Ackart, editor of the Virginia Medical Monthly, has pointed out, health insurance isn't like automobile insurance: A dented fender doesn't have to be repaired right away, but often a dented human being must be.

If a man does a few dollars' worth of damage to his car, he can usually keep on driving for months without harming it. But the man who puts off seeing a doctor about a pain in his chest because he can't spare \$5-well, he may be really sick by the time he finally gets attention.

Studies we've done at the Health Information Foundation indicate that it's mainly before diagnosis that people try to save on medical care. I think all doctors will agree with me: That's a poor way to save money. Comprehensive coverage tends to eliminate such bad economy.

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I don't mean that deductibles and co-insurance have no place in health insurance. But I think they've got to be set so that they don't discourage the first visit. One possibility is a policy that gives the patient the first \$50 worth of medical service in full, and requires him to share the cost only thereafter.

#### Too Costly? No!

4. "Comprehensive coverage costs more than people will pay."

Where comprehensive plans now exist—whether medically sponsored, as in Canada and Washington State, or lay sponsored, as in the closed-panel plans—experience has proved the opposite. The higher premiums don't stop workers or employers from signing up.

Our own opinion studies at H.I.F. indicate that many Americans would be willing to spend more than they now do for medical care-provided they could do it on a budget basis.

As I've already said, people do

consult their doctors more freely when they've got comprehensive coverage. Of the total U.S. population, about 60 per cent see a physician at least once in any given year. Where people have health insurance that includes home and office calls, this figure rises to 70 per cent.

#### They're Well Cared For

What sort of people are these extra patients? Many of them are persons over 65 who probably wouldn't be seeking medical attention if it weren't for their more comprehensive insurance. Of the total population of over-65s, a quarter have never in their lives had a physical examination! Another quarter haven't had one within five years.

If comprehensive coverage sends such individuals to their physicians, I call it good medicine. In addition, it creates a sounder financial base for all health services.

Right now whole segments of the American population can afford good medical care but don't get it because they can't budget for it. Until they can do so, health insurance isn't likely to take its rightful place in the expanding American economy.



### Who Dreams Up the

Meet one of many designing doctors. This man has produced 38 new surgical instruments that save time, motion, sometimes even lives

By Donald H. Johnston

Some doctors fish or play bridge as a hobby. Dr. Ernest B. Emerson Jr. designs surgical instruments.

By way of relaxing from his chores as surgeon and assistant professor at the University of Rochester Medical School, Dr. Emerson sits down at a card table in the living room of his Rochester, N.Y., home. There, with his tiny jeweler's tools and brass models, he has worked out thirty-eight different surgical instruments that have found their way into the commercial market. His inventions

range from an endotracheal catheter gun to intra-bronchial calipers, from an arterial curette to an operatingroom light for endoscopy. He has another fifteen implements in the rough or experimental stage right now and lots of still untried ideas.

"It's a time-consuming hobby," the 43-year-old surgeon concedes. "But it gives me great satisfaction as well

### Instruments You Use?

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as relaxation." To understand what he means, consider the case of one of his own patients: 9-year-old Linda Crawford.

Linda was unable to eat solid foods. As a baby, she had drunk a strong disinfectant by mistake. It had burned the inside of her esophagus. As the burns healed, strictures had formed inside the tube, preventing her from swallowing anything but liquids and strained foods.

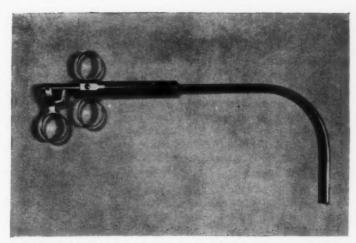
An eight-year program of treatment failed to dilate the child's esophagus, so a chest operation was performed. This accomplished the removal of all the strictures except two.

"It looked as if we were whipped," Dr. Emerson recalls. "Our only hope seemed to be to transplant a piece of Linda's intestine to serve as a substitute esophagus—a

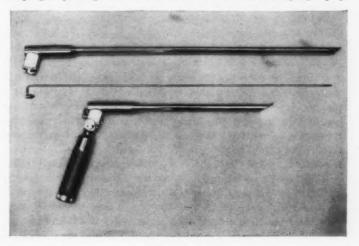
#### WHO DREAMS UP YOUR INSTRUMENTS?



INSTRUMENT DESIGNER: Dr. Ernest B. Emerson Jr. inspects some of the thirty-eight surgical instruments that have so far found their way from his living-room workshop into the commercial market. He's a bronchoscopist.



TANGIBLE RESULTS of Dr. Emerson's inventiveness are an endotracheal catheter gun that permits one surgeon to do a two-man job [A] and a ribbon esophagoscope designed to remove strictures from inside the esophagus [V].



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tricky and rather dangerous operation."

As a last alternative, he wanted to try cutting out the accumulated scar tissue from the inside of the esophagus. He thought it might be done in such a way as to prevent the scar tissue from growing back. The only drawback: There were no instruments suitable for such an operation. "If I wanted to proceed," he says, "I had to design my own instruments."

So that's what he did. After several long sessions at his card table, he perfected a new ribbon esophagoscope and an esophageal resection knife. They were used in a series of operations on Linda. Not long ago, she ate her first solid food in eight years.

#### He Won't Take Money

It used to cost the doctor almost \$1,000 a year to machinetool his inventions for presentation to manufacturers. Now that his work is known, the manufacturers have taken over some of this for him. They'd probably pay him well for his ideas, if he'd let them. But he won't. None of his implements is patented, and he gets no financial return from any of them.

How did all this begin? Dr. Emerson traces his hobby back to an electric train his wife gave him in 1938. At that time, he was an interne fresh out of the Rochester medical school; and his wife thought he needed something to help him relax after his long hours at the hospital.

#### How He Got Started

In order to tinker with the train, the young M.D. collected a set of tiny tools. Then one day at the hospital a surgical instrument broke-and Ernest Emerson had the only screwdriver small enough to fix it.

From that point on, he found himself using his little bag of tools more and more for professional gadgets and less and less for toy trains. "As I took a keener interest in instruments," he says, "I saw the need for new and improved designs. And whenever my surgical colleagues told me about some instrument problem, I just couldn't keep from going to work on it."

His first successful instrument was a radium applicator for the treatment of deafness. It resulted in brand-new treatment techniques; and its widespread acceptance showed the doctor how

his hobby could help his profession.

While he does most of his designing for his own specialty of bronchoscopy, Dr. Emerson sometimes strays from the field. He gets two or three inquiries a week from surgeons all over the world, and he can't resist tackling some of their suggestions. He's working on one now: a series of instruments that would make possible an operation to remove blood clots from the large arteries of the leg.

#### Sources of His Ideas

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He finds ideas for instrument parts in unlikely places. For example, he's trying out an adaptation of an old-fashioned apple corer in his blood-clot-removal project. From observing the spiraling stem of a child's spinning top, he hit on the idea for an arterial reamer. And the clutch on his endotracheal catheter gun is a miniature of one on the engine of his old inboard motor-boat.

Once he's perfected an idea, he carries the result through the brass-model stage. Then he turns it over to a manufacturer.

Has he had any so-called "lemons"?

"You bet—particularly at the beginning," he says. "A designer has to expect slip-ups. He's got to experiment with all sorts of unorthodox notions. Some of them are bound to prove impractical. But no failure is a complete waste. I hold onto the ideas for future instruments."

Five different companies have marketed Dr. Emerson's implements over the years. But he now limits himself to one firm (Welch Allyn, Inc.) in Skaneateles Falls, a short distance from Rochester.

"With my tight schedule, it's more convenient to work with a single company," he explains. "If I can get away for a few hours, I drive to Skaneateles Falls with two or three ideas. I talk them over with the patternmaker, the machinist, and company executives. In one afternoon, we often get things settled."

## Week-end Tinkerer

Dr. Emerson has to do most of his tinkering late at night or on week-ends. As for his family: "Well, I see more of my wife and two kids than you'd expect," he says, smiling. "They often sit around the living room and watch me work. They like my hobby too."



Planning Your Family's

# Nine Provisions Not

After observing the mistakes that doctors most commonly make, this lawyer has come up with a check-list of nine testamentary 'don'ts'

By René A. Wormser, LL.B

Before you ask a lawyer to draw up your will, you'll probably want to rough out your own draft of it. That way, you'll be able to crystallize your ideas in nonlegal language.

I'm strongly in favor of such rough drafts. They save the lawyer time and thus save his client money. But to be truly helpful, they ought to be realistic. And, in my experience, they often aren't: They're likely to include provisions that are legally unsound or else impractical.

To help you stay within the bounds of law and prudence, I've put down a number of "don'ts" that you might well keep in mind. Naturally, these bits of advice about what *not* to include in your will won't cover every possible angle. But they'll help you avoid some of the errors that doctors commonly make.

THE AUTHOR combines a busy law practice with teaching, writing, and lecturing. He's chairman of the advanced estate-planning panels at the New York Practising Law Institute. He's also the author of a number of books. One of them, "Personal Estate Planning in a Changing World," is considered the standard layman's guide to the subject.

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# to Include in Your Will

1. Don't put burial instructions in your will. Reason: They may not be found until it's too late to follow them out. Better give such directions separately to your family.

I recall one case in which the will of a certain G.P. stated clearly that he wanted to be buried in an inexpensive coffin with the simplest of services, attended by family members only. But, as often happens, his family didn't see the will until after the funeral—a big one featuring the doctor in a \$3,500 embossed-bronze casket.

2. Don't make unqualified cash bequests in your will. The results of such testamentary gifts can be disastrous. For instance:

A doctor in my city left "\$15,000 to the Blank Medical School, and all the rest, residue, and remainder of my estate to my wife." When he made the will, he was worth close to \$150,000. His obvious intention was to leave about 10 per cent of this to his medical school.

But during his terminal illness the bottom dropped out of his principal investments. So his estate came to only \$45,000. The school still got its \$15,000—a fat one-third of the total. The doctor's widow got just \$30,-000, less taxes and expenses.

How should the doctor have worded his bequest? Well, if he had bequeathed the school "\$15,000 or 10 per cent of my residuary estate, whichever is less," his widow

would have been a lot better off.

3. Don't include recriminations in your will. Besides being in questionable taste, they can cause legal trouble. For example, courts have ruled that a man's estate can be sued for libelous remarks in his will. So think twice before you accurately characterize that no-good brother-in-law of yours in your last testament.

4. Don't make small bequests of personal items to friends or employes. If there are works of art, special scientific collections, or other personal effects you want to dispose of, it's best to leave all such items to your wife (or someone else in whom you have complete confidence) and rely on her to distribute them as you want.

### Leave a Note

You can tell her about it beforehand. Or you can leave her a note. Such informal instructions won't be legally binding; but they're the best way to handle the situation. Here's why:

Since personal effects are usually small, sentimental gifts, they don't bulk large in the average man's thinking about his estate. If, after several years, he knows the main provisions of his will are still all right, he's not likely to review it merely to check over minor bequests. The frequent upshot: all sorts of confusion.

By the time the doctor is dead. for one thing, some of the people named for minor gifts may also have died. Even if they're all still living, some of the bequests may have become totally inappropriate because of changed circumstances. In one case I recall, a physician's family was more than mildly upset to discover he'd left a valuable heirloom to an aide he'd fired the year before for petty thievery.

5. Don't give away property that's not yours to give. If you live in a community-property state, better double-check the legal ground rules on what's yours and what's your wife's.

(The eleven community-property states: Arizona, California, Idaho, Louisiana, Nebraska, Nevada, New Mexico, Oklahoma, Oregon, Texas, Washington.)

6. Don't try to disinherit your wife. In most places, it can't be done. Almost everywhere, the survivor is entitled by law to a minimum share of the estate. The exact proportion varies from state to state, but it's commonly about one-third.

when one husband Thus, willed his wife "one dollar and a loud laugh," the joke boomeranged: His widow had the last laugh.

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Furthermore, in some states, you can't disinherit a child.

### Leave the Family Some

- 7. Don't try to leave everything to charity. Even if you're a widower, you may not be able to do so. Many states strictly limit charity bequests when there are any living members of the immediate family.
- 8. Don't plan on disposing of your practice by will. The value of a medical practice shrinks so rapidly after the practitioner's death that your executor may realize little more than the going value of the physical assets by the time he can get around to arranging for a sale. One practice that was worth \$40,000 when the doctor was living went for \$9,000 only three weeks after his death.

To be sure, it isn't always feasible for a man to sell his practice before death-even in "slow motion," as previously described in MEDICAL ECONOMICS [February, 1956]. But wherever possible the older physician should consider doing so. Otherwise, his unhappy family may find that what was a large income-producing practice has suddenly depreciated to almost nothing.

9. Finally, don't name anyone as executor unless you've got his consent. Even though he's a close friend, your executor may resent having the job suddenly sprung on him. He'll work best for your interests if you've prepared him for the news.

Actually, it's wise to do more than merely get his consent. It's a good idea to go over the will with him, explaining any clauses that aren't immediately clear to him. If you anticipate false claims against the estate, he should be warned of them-and of all probable legitimate claims, too. He should understand your financial records, so that he can make an intelligent effort to collect any money your patients owe you.

## Can You Trust Him?

Remember that your executor will be your alter ego when you're gone. Better take him into your confidence ahead of time, while you can still guide him. If you can't trust him with a complete knowledge of your affairs now, is he really the man to be trusted later on? END



# Four Problems That

EDITOR'S NOTE: There was a time when David B. Allman did 40 per cent of all the surgery done in Atlantic City, N.J. Now, seven years after his professed retirement, he's about to shoulder an even bigger load: the Presidency of the A.M.A.

Dr. Allman still has the same office furniture with which he began practice in 1915. He visited his patients that year on foot, until he saved up the \$500 it took to buy a car. He believes a doctor should work hard, keep his fees low, and build up a devoted group of patients. That's the only way to achieve real professional security, he says, without loss of professional independence.

Today David Allman belongs to forty-two organizations. Aside from his high offices in organized medicine, he has held such interesting posts as official physician to the Miss America Pageant and honorary chief surgeon Dr. David Allman speaks his mind on the care of the aged, the future of Blue Shield, too much specialization, too much Government medicine

# Medicine Must Solve

of the Atlantic City Fire Department. In fact, the fire alarm still rings in his office whenever it rings in the Atlantic City Firehouse. It appropriately punctuated the accompanying interview with Lois R. Chevalier, MEDICAL ECONOMICS' research director.

# Problem #1: The Care of the Aged

Q. Dr. Allman, you probably have a better birdseye view of American medicine than most doctors. What would you say is the most important single problem facing the profession today?

A. One problem stands out well above all the others: the care of the aged. The increasing number of people over 65 is something medicine is largely responsible for. So we must help solve the resulting problems. [MORE]

Q. Are you referring to medical problems or to economic problems?

A. Both. Medically speaking, we have to develop special knowledge and special techniques to keep older people happy, comfortable, and well.

Q. Then do you believe geriatrics will become a full-fledged specialty?

A. In a sense it is now. At least it's already a subspecialty of internal medicine.

Q. Suppose a young internist came to you and said: "Dr. Allman, I think geriatrics is a coming field. I'm fond of old people and I think I'd like working with them. What's your advice?"

A. If he were just out of residency, I'd give him the advice I give any young man: Do general practice for at least two years. After that, if he still wants to go into geriatrics, he should go to some medical center for another year's training under a good geriatrician. When he comes back and starts practice and lets his colleagues know he's interested in geriatrics, he'll have sufficient referred work in no time. Most other practitioners aren't interested in this field. They'll be glad to send him cases.

Q. Why aren't they interested?

A. Well, if a man is wellestablished in gynecology or dermatology, he'd be foolish to devote time to an unrelated subspecialty. The aged do demand and need-more time and attention than the average patient.

Q. What about the economic implications?

A. There are many older people in financial straits. Those who have retired on pensions are victims of the devaluation of the dollar, and they're finding it hard to maintain a normal existence. They're unable to get health insurance because of their age. The expense of going into a nursing home or getting any kind of care is more than they can meet.

O. This creates economic problems for the geriatrician.

A. Of course it does. But not all these people are medically indigent. Many have children or other relatives who will see them through a crisis.

Q. Are there ways in which we could increase the proportion of elderly people who can afford medical care?

A. As I see it, the best way is to encourage people when they're young to take out health insur-

ance of a type that will carry through their old age. People must learn that the closer they get to old age, the less available this insurance is to them. They must buy it when they're young.

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Q. But doesn't a lot of coverage automatically terminate when people retire?

A. Yes. But there's been a noticeable improvement recently. Only today, in the Atlantic City paper, I saw an advertisement of an insurance company saying you can be insured up to age 100.

Q. They don't mean they'll take you on at 100, but they'll continue you to 100. Right?

A. Of course. Many companies used to terminate their policies at 65. Now they'll write them to 70 or 75. We of the A.M.A. are doing all we can to encourage this. As a matter of fact, the U.S. Department of Health, Education, and Welfare is rather insistent that we accomplish something in this field.

## Problem #2: The Future of Blue Shield

Q. While Blue Shield and the commercial health insurance companies are all growing at a phenomenal rate, I think it's generally conceded that commercial coverage is spreading faster. Why is this?

A. Actually, I think there may be a variety of reasons. One possible reason is that Blue Shield in some areas is tacked onto Blue Cross coverage when it's offered to the public and to the various employe groups.

As Blue Cross premiums are raised, and as they start to meet more and more sales resistance, naturally Blue Shield is going to

suffer by not having its own sales agency.

Q. Dr. Allman, some medical leaders have pointed out that if the commercial carriers continue to expand in the health insurance field, they may make the going pretty rough for Blue Shield. In fact, some think that once commercial carriers have covered the field adequately, there will be no further need for Blue Shield. What's your own opinion on this?

A. I have always had the feeling that there was a job to do, and that there's plenty of room in this field for both types of

#### FOUR PROBLEMS FOR MEDICINE

organizations. The A.M.A. is interested only in seeing that the American people get adequate medical care and that they have no undue financial burdens when such care is necessary. We don't care who does the job, as long as it's done.

Q. Blue Shield people say there'll always be a need for a nonprofit organization that will

serve the whole community, not just the best-risk groups.

A. I think they have a point there. But it may not work out that way in practice.

Of course, I think the very existence of Blue Shield has made the commercial carriers more alert. And I think the competition has been helpful to the general public.

## Problem #3: Too Much Specialization

Q. Everyone admits that specialization has brought improvements in techniques and knowledge. Do you feel there are disadvantages to it as well?

A. Of course there are. I think the pendulum has gone about as far in the direction of overspecialization as it will ever go. From now on the trend should be back to more and more general practice.

And I think you'll find that the specialist will become less limited by the confines of his own special field. There's been a misconception among many young doctors that it would jeopardize their standing with their specialty boards if they saw any patients outside their particular specialty.

Just last week I was discussing this with people on the various specialty boards. I found that under certain circumstances the boards have no objection to a specialist's doing anything that may be required of him. Many of the conceptions these younger men have are false.

For example, some young men have been reluctant to work on civil defense programs because they thought it might interfere with their standing as specialists. I'm reliably informed that this isn't so. In the event of any civilian or military disaster, any specialist should be perfectly free to work in any medical capacity whatever.

I also notice that some young

men are reluctant to take emergency calls from the systems set up by county medical societies. They seem to fear that if they put their names down to take night calls, they may get cases that are not in keeping with their board standing. Well, they're wrong. A specialist should have his name on the emergency call list. He should take any call that comes in during the time he's on call.

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Q. Suppose a young surgeon who has just hung out his shingle is confronted by a patient who has walked into his office with, say, a sore throat or a bellyache. What

should he do? Should he send the man down the street to a general practitioner?

A. Well, the man who holds himself out as a qualified surgeon shouldn't attempt to enter the field of general practice. But an occasional case may be all right. If someone walks in late at night with a stomach-ache, he certainly should receive help.

Q. If specialists start doing occasional general practice, what does the future hold for the G.P.?

A. In my opinion, he'll come into his own again within the next decade. As I told you, I think the



"What really gets him is when I try to kiss him."

pendulum has swung as far as it will. I think the next swing will be back toward more general practice. And it'll be a healthy change.

Q. But the young men coming out of school-they're not choosing general practice in any great

numbers yet, are they?

A. That's because they've been so indoctrinated with the glamour of a specialty that they don't know the true facts of life. In reality, general practice is probably the most rewarding form of all practice, and I'm certain more and more young doctors will come to realize it. General practice is where you have the closest liaison with the familywhere you gain your patients' respect not only as their medical adviser but also as their friend. There's something wonderful about the trust a family will put in

a general practitioner. It far outweighs any economic advantage a specialist may have.

Q. Do you think the specialist will retain that economic advantage? Or will it be affected by further splitting up of the specialties? For instance, what if general surgery keeps on breaking down into surgical subspecialties?

A. The future of general surgery isn't as bright as it was when I started out in the field. At that time there were no gynecologists, no proctologists, no ENT men. So a well-trained surgeon did all kinds of surgery-and I might add, did it well. Today it's praçtically impossible for any man to keep up with all the advances on such a broad front.

Q. Do you think general surgery will disappear?

A. As I knew it thirty years ago, it has disappeared.

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## Problem #4: Too Much Government Medicine

Q. In your position, you're well aware of the interplay of government and medicine. I think doctors everywhere would be interested in your ideas about the proper role of government in relation to medicine.

A. Aside from the services that normally belong to public health, government has no function in medicine. Any extension of government into the practice of medicine is detrimental to the advancement of medicine and therefore harmful to the health of the American public.

American medicine has developed the most healthy living conditions in the world. And it has done so on a free enterprise basis. Any government interference in any medical matter will curtail advancement by destroying the initiative of the doctor. Regardless of arguments to the contrary, as soon as controls are put on an individual scientist, his efficiency decreases. He becomes a laborer rather than a scientist, and he has no incentive to advance.

If that were to happen here, the high standard of American medicine would fall, as has happened in places like England. There's no question about it: Government doesn't belong in the practice of medicine any more than it belongs in business.

Q. What are the accepted functions of public health?

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A. Water pollution, Indian health—things like that. And I might as well include the Veterans Administration in so far as it handles service-connected injuries to veterans.

We in American medicine feel that any veteran with a serviceconnected condition is entitled to the best attention possible—at Government expense. But we do not feel that non-service-connected conditions should be taken care of by the Government. The Government oversteps its bounds when it tries to give any veteran any care at any time in a veteran's hospital.

Q. Suppose Congress comes around to your point of view. What then? What happens to the V.A. hospitals that have been emptied of non-service-connected cases?

A. I don't know what could be done with such facilities. They might be taken over by the communities or by the states. But no matter what, the mere fact that millions of dollars have been wasted on the construction of unnecessary V.A. hospitals should not deter the Government from getting back on the right track.

The A.M.A. has been telling Washington for years not to put up more V.A.hospitals. The fact that it has wasted so much money to build up a bureaucracy is no excuse for wasting millions more on maintaining and operating needless facilities. It would be more economical for the Government to give the states the buildings than to try to operate them in the present fashion.



# A Budget Building That's Rich in Extras

By Lois Hoffman

It's not hard to build a first-rate office if you have a big bank account. But the man who's short on dollars needs to be long on ingenuity.

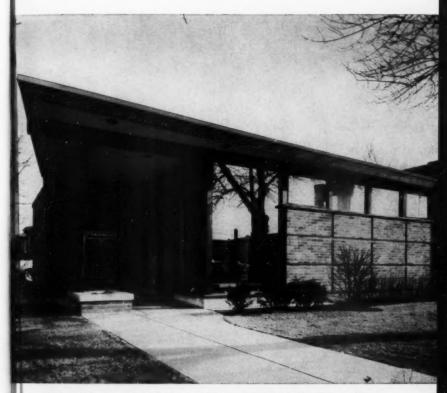
The G.P. and his architect who planned the building pictured on these pages worked their ingenuity overtime. The doctor couldn't afford to spend more than about \$20,000. But he wanted a good deal for his money—including a spacious reception room, two large combination examining-consultation rooms, a laboratory, two lavatories, air conditioning, and a parking lot.

He got everything he wanted—and more besides.

The building has about 1,300 square feet of floor space. It cost only \$13.50 a square foot, as compared with the usual \$16 for similar construction in its locale (Chicago).

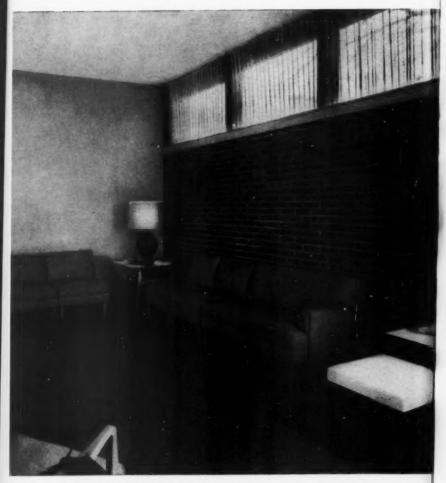
How was the cost kept so low? Here's the answer:

By designing the building as an almost perfect square, the architect squeezed the greatest possible amount of interior space into the smallest possible amount of expensive exterior wall. In addition, he avoided costly excavation by tucking the furnace neatly away in a corner. And, finally, he saved on construction costs by specify-



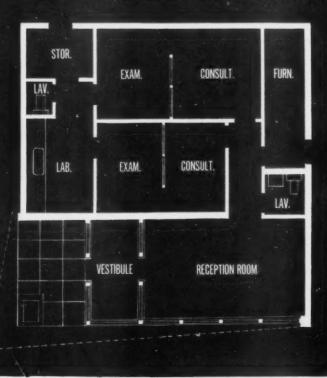
NO EXPENSIVE FRILLS obscure the basic good lines of this one-man office in Chicago. Though almost a perfect square, its jutting overhang and asymmetrical design make it far from boxlike in appearance. Cost: \$13.50 a square foot.

#### BUDGET BUILDING WITH EXTRAS



LIVING-ROOM STYLE of the reception area makes patients feel at home. High windows give extra wall space for sectional pieces that can be regrouped at will. Tough but inexpensive carpeting cuts noise in the 20' x 12' room.

COMPACT AS A K-RATION, the office gives no impression of crowding or pinchpenny economy. Yet it contains almost no unused space. When the doctor is ready to see his next patient, he leaves the consultation-examining room by the nearest door. He enters the building through the storage room just off the parking lot. Repairmen use the furnace-room door.



ing stock furnishings, materials, and fixtures rather than custom items.

The office is relatively small. But the doctor says its compactness has brought him an important extra benefit: It helps him conserve energy. Since the building has no long halls, a few steps take him wherever he wants to go.

Another unexpected extra: Because easy-to-clean wall coverings are costly, the walls of the office were finished with a coat of tinted plaster that had coarse sand mixed in. This surface has proved not merely pleasant to look at but remarkably practical. Its roughness doesn't invite the touch of sticky hands—which means that dirty fingerprints seldom have to be scrubbed off.

## **Peace and Privacy**

The building stands on the corner of a busy street lined with bars, used-car lots, and hot-dog stands. Yet, within the office, the visitor is immediately aware of an atmosphere of peace and privacy. This is chiefly because there are so few windows.

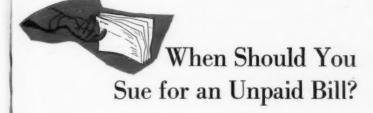
The one glazed area is in front. In the reception room there are windows, but they're set far above eye level. While waiting patients can look out through the vestibule (which is glassed-in on three sides), it's difficult for passers-by to see in—or for noise and dirt to penetrate.

## Intruders Discouraged

What's more, the lack of windows is a deterrent to potential narcotics thieves and destructive teenagers. The only vulnerable place is the vestibule, which is kept floodlit at night (and which faces on the heavily patrolled business street).

In general, the doctor is well pleased with his set-up. He says he has only two regrets: (1) that he couldn't afford acoustic tile on the ceilings and (2) that he didn't install sliding doors between the laboratory and examining rooms.

To an outsider, the lack of business-office space might seem an added drawback. (Files are kept in the laboratory, and the nurse does paper work at a small desk in the larger consultation room.) But the G.P. insists he likes it this way. And if he ever changes his mind, there's enough space for partitioning off a private nook where the aide's desk now stands.



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Before you try to collect via the law courts, consider this check-list. It suggests ten important ways to make sure of your timing

By Leslie S. Kohn, LL.B.

A doctor-friend of mine stopped me in the street the other day. He had a folded newspaper in his hand. "You're just the man I wanted to see," he said. "You've always advised me to sue any delinquent patient who was clearly taking advantage of me. But look at this story."

He flourished a news article in front of my eyes. "Here's an old fellow who's been in practice for fifty years," he went on. "They're giving him some kind of award. He says he's never dunned a single patient, and he guesses he's lost thousands of dollars that way."

The doctor shook his head. "Nobody likes to lose money," he said thoughtfully. "And yet..."

I knew what he meant. Now, in his old age, the physician in the newspaper story was obviously both prosperous and beloved.

The very thought of being venerated by a whole community gives my friend a warm glow. But at the same time he gets hot under the collar at the prosperous patient who blandly ignores his bill. Which feeling should he cater to?

I'm a counselor-at-law, not a counselor on etiquette. I can't pass judgment on the public-relations or ethical aspects of litigation with patients. But from an outsider's standpoint, it's quite obvious that the doctor must weigh these main pros and cons:

Pro: The doctor who sues on just provocation will, of course, collect more of his bills than the one who shrugs his shoulders and gives up. A suit may also produce a certain amount of emotional satisfaction: It tells the world that the doctor won't be imposed upon, won't cringe before a freeloader who can afford to pay his own way. A suit can even help the profession generally-since the patient who escapes payment because of one physician's reluctance to sue often takes advantage of some other physician later.

### Reasons Not to Sue

Con: The doctor who starts litigation may find that the patient is thus encouraged to file a malpractice claim by way of reprisal. A suit may also expose the

practitioner to gossip that he's cantankerous and money-happy. Finally, in these days of sensitive public relations, a suit—if widely and unfavorably publicizedcan backfire on the profession at large.

These are factors that every doctor must weigh for himself. The wisdom of starting suit, I believe, is up to him. The timing, however, is another matter-and one where the physician needs legal advice.

#### **Check This List First**

Litigation to collect a bill is generally in order:

- 1. When the patient can afford to pay without hardship.
- 2. When the doctor can produce office records that support the bill.
- When the doctor can justify the size of the bill by comparison with fee practices in his community.
- 4. When the patient's general condition after treatment is satisfactory.
- 5. When the persuasive powers of an ethical collection agency have been exhausted, and the agency advises suing.
- 6. When the patient has been given ample warning of the doc-

tor's intention of collecting by legal means.

7. When the patient (or defendant) is not judgment-proof.

When the defendant is legally liable for the services rendered to the patient.

When the statute of limitations has ruled out any possible malpractice action.

10. When the doctor is not bubbling over with indignation or in a "he-can't-do-that-to-me" frame of mind.

The experienced practitioner ticks off these ten "whens" be-

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fore he plunges into litigation. Only with all of them in his favor does he instruct his attorney to file suit. Contrariwise, if any of these factors is clearly adverse, he postpones formal legal action, perhaps even writes off the account.

One thing *not* to worry about is loss of time attending court-room sessions. Chances are, the doctor won't be required to appear personally. Nine out of ten suits for medical fees, in fact, are uncontested by the debtor.

The statute of limitations an-



"Well, last night the pain started here . . ."

gle may be more tricky. If the doctor negligently damages a patient, that's a"tort." If the patient fails to pay his bill, that's a "breach of contract." Generally, the statute of limitations is shorter for a tort than for a contract. It may, for instance, be three years and five years respectively.

In that case, if the doctor starts suit four years after the service was rendered, he'll be well within the five-year limitation on contract actions; but the patient won't be able to counterclaim for malpractice, since the deadline for a tort action has passed. (The exact time periods, of course, vary from state to state.)

#### Here's the Rub

There's one catch to this. In a few states, it has been held that when the doctor starts the suit, he waives his right to bar the malpractice counterclaim. The theory, as stated in one famous case: "When the plaintiff [doctor] commenced this action, he invited the defendant [patient] to take advantage of any infirmity that affected the transaction, even though the defendant [patient] would have been barred by limitation from instituting independent action."

Hence, before assuming he's immune to a counterclaim, the doctor had better check with his lawyer on the rule in his state.

#### Who's Liable?

What about the defendant's liability? The question may arise in circumstances like these:

The patient is a child living with a mother or grandparent, while the separated father is the defendant. Or a domestic is treated at the request of the housewife. Or treatment is rendered to a wife living apart from her husband; to an employe at the request of the employer; or-in an accident, perhaps-to an unconscious patient. It takes a lawyer to steer through these shoals and determine who is legally liable for the bill.

Before a trial begins, no litigant can see any merit in his opponent's case. It seems crystalclear to him that truth and justice are on his side. As a result of this psychological blind spot, the doctor embroiled in bill litigation assumes that the patient will have no defense-except maybe "I don't feel like paying this bill."

The physician may be shocked to discover how loud (if not how sound) a case the defendant can

put up. Here, for example, are seven common defenses that the doctor must be prepared to meet:

¶ Results were bad.

¶ Statute of limitations has expired on the contract action.

Number of visits was fewer than itemized on the bill.

¶ Results achieved were not those promised. (For example, the doctor may have said: "You'll feel better after three or four injections." The patient did not feel better. It's often alleged

that the physician implied a cure and failed to produce it.)

The doctor failed to give the patient any idea of cost. (Example: The patient came prepared to pay a regular fee. The doctor gave him an injection of a new antibiotic. When he got a bill for \$15 for that one visit, the patient balked.)

The defendant is not legally liable. (He didn't authorize the service, or is not responsible for the patient.) [MORE ON 328]



"Oh, yes . . . No matter what the internes say, you're not required to help them learn anatomy by the Braille system."



# How Do Good

By Lois Hoffman

EDITOR'S NOTE: How did you get to be the kind of doctor you are? Do you think you might be somewhat better than average because you went to a world-famous medical school? Because you have a slew of medical society and hospital affiliations? Because you keep up with current medical literature and take regular post-graduate training?

Don't be too sure.

Apparently most of us have been cherishing some false notions as to the type of training, experience, and practice methods that help to make a doctor *good*.

This conclusion emerges from a pioneering study sponsored recently by the Rockefeller Foundation. Though the study was intended solely as an appraisal of general practice—and of the type of training most likely to turn out competent G.P.s—it's of interest to every doctor, no matter what his field.

# Doctors Get That Way?

1. A Look at Your Practice Methods

If you were to peer over a colleague's shoulder while he treated a full month's roster of patients, you'd get a good idea of his competence. Since you can't do this, you judge his skill—at least in part—by the kind of medical school he went to, his hospital and medical society affiliations, his diligence in graduate work, and his apparent prosperity or lack of it.

How accurate are such valuations? Not very, if we can draw conclusions from a limited but intensive study made by a research team from the University of North Carolina medical school.\*

Members of the team spent months in a detailed onthe-spot examination of the practices of eighty-eight family doctors scattered through the state. One team member (and sometimes two) followed each G.P. through three or four days of office, hospital, and house calls, noting what he did and how well he did it.

Director of the study was Internist Osler L. Peterson, a staff member of the Rockefeller Foundation and of the Division of Health Affairs, University of North Carolina. Internists Leon P. Andrews and Robert S. Spain did most of the field work, with an assist from Psychiatrist R. W. Howell. Biostatistician Bernard G. Greenberg evaluated their findings, which were reported in December, 1956, by the Association of American Medical Colleges in "An Analytical Study of North Carolina General Practice, 1953-1954."

#### HOW DO GOOD DOCTORS GET THAT WAY?

Each doctor was graded on six activities: history taking; physical examination; use of laboratory aids for diagnosis; therapy; preventive medicine; and keeping of clinical records. Then his clinical skill, as rated by the researchers, was stacked against his medical school record, interneship, patient load, medical society and hospital affiliations, family background, office facilities, and so on.

Chief aim of this study was to discover what it takes to make a really competent G.P. Its most striking conclusion: Many common assumptions about what makes a good doctor are false.

The researchers found, for instance, that a Harvard man may be no better—and no worse—a family doctor than an alumnus of Podunk U. The G.P. with hospital connections may do no better by his patients than the

# **Average Clinical Performance Scores of 88 G.P.s**

Rank	No. of G.P.s	% of G.P.s	Activity						
				Physical Exam.		Therapy	Preven- tive Med.	Clinical Records	Total Score
V	7	8%	76%	62%	73%	77%	81%	80%	72%
IV	15	17	53	53	66	57	87	75	58
111	27	31	29	34	47	40	62	35	38
11	23	26	18	19	39	24	49	30	25
I	16	18	16	16	28	12	49	15	21

A research team scored eighty-eight North Carolina G.P.s on their performance of six clinical activities. Then they grouped the men according to how well they'd made out. The top group was called Rank V, the lowest group Rank I, with Ranks II to IV in between. The table shows the average score (expressed as a percentage of a possible "perfect" score) chalked up by each group of doctors for each activity, as well as their average total score.

man who has none. (But the physician who sticks to an appointment schedule is very likely to outshine his "come-in-any-time" colleague.)

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These and other findings will be discussed in a series of articles, of which this is the first. The findings have interesting implications for you, whether you happen to be a specialist or a G.P.

#### Done Your Best?

They may confirm your impression that you've done everything possible to become an efficient, skillful doctor-and your determination to stay that way. On the other hand, they may suggest some desirable changes in your post-graduate study habits, your office routine, or some other aspect of your practice.

First of all, though, they can give you a new slant on yourself as a doctor. If you-rather than one of the eighty-eight North Carolina G.P.s-had opened your office to an observer, how would he have rated your competence? What aspects of your medical practice would he have considered most important?

In the North Carolina study, the researchers assigned the following "values" or points to the six medical activities studied:

Medical history . . . . . 30 points Physical examination. . 34 Use of laboratory aids. 26 Therapy . . . . . . . . . 9 Preventive medicine .. 6

Thus, diagnostic procedures accounted for 90 points out of a possible 107. Reason: The research team considered the family doctor's primary role to be that of "first-line diagnostician."

Clinical records . . . . . 2

It's true, of course, that the G.P. sees many more "unsorted, unclassified" cases than the man with a large referral practice. But no doctor can prescribe the right therapy (or call in the right consultant) until he has a good idea what ails the patient. So the study findings should be applicable to almost any type of practice.

## **Revealing Comparison**

This is so even if you'd be inclined to place entirely different values on the ingredients of your own practice. For example, you may consider therapy more important than the medical history. Yet a comparison of your methods with those of the North Carolina G.P.s may still be revealing MORE to you.

#### HOW DO GOOD DOCTORS GET THAT WAY?

The study shows that a given doctor is likely to display much the same degree of competence in everything he does: The North Carolina man who took a careful history was almost certain to do a thorough physical, and so on (see table below). So no matter what point value had been

attached to each activity, the same men would have come out on top. No doctor was given a high rating because his brilliant performance in one field overshadowed his inferior performance in another.

It so happens that comparatively few of the North Carolina

## Critical Sidelights on

A careful reader is bound to challenge certain aspects of the North Carolina study. The researchers themselves did some challenging: In the study report they dissect their methods and findings, to show up weaknesses where they exist and to justify conclusions that seem justifiable. Here are the main criticisms of the project, along with clarifying comment based on the North Carolina researchers' report:

The eighty-eight G.P.s may not have been typical.

In type and length of hospital training, at least, they were much like G.P.s everywhere. And they had come from fifteen different states and had attended thirty-two different medical schools. Included among them were good students and poor ones. Some of the men had done no post-graduate work, others had done over sixty hours a year. They practiced in cities, small towns, and rural areas. Their ages ranged from 28 to 65.

To draw any sweeping conclusions from a study of only eightyeight men is unwarranted.

G.P.s were given a high rating: In the researchers' opinion the substandard clinicians outnumbered the budding Oslers by almost two to one. The observers found twenty-two men to be better than so-called average, thirtynine worse. Here's the method they used for ranking the G.P.s:

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After completing his study of a man's practice, the observer summed up his impressions by assigning the G.P. to one of five ranks designated by Roman numerals. Numeral V stood for an excellent clinical performance, I for a very poor one, with III "average" or fair. Ranks II and

# the North Carolina Study

The researchers agree. That's why they're now planning further studies which they hope will shed more light on some of their initial findings.

A test based on personal observations can't be completely impartial.

True. Even though the researchers used a rigorously detailed check-list, they found that one of them gave consistently higher ratings for the physical examination. All ratings were standardized in the final accounting. But in a test of this sort no mathematical computation can completely overcome the effect of personal bias.

Daily practice can't be judged by textbook standards.

These are probably the only standards most doctors would agree on in principle. Besides, one purpose of the study was to compare the G.P.s' skill as practitioners with their medical school grades. This wouldn't have been possible unless much the same criteria had been used in both instances.

#### HOW DO GOOD DOCTORS GET THAT WAY?

IV represented intermediate grades. The number of G.P.s finally assigned to each rank was as follows:

In other words, only seven of the doctors received the highest grade. Why? Because, the report says, only they knew exactly what they were doing and did it thoroughly and systematically. Even more important, they showed real interest in patients and their problems. They seemed to enjoy the intellectual challenge of medicine.

At the other extreme, the report states, Rank I doctors did a sketchy, haphazard job. Sometimes the researchers simply

#### CRITICAL SIDELIGHTS (Cont.)

When a doctor gets too busy, he HAS to lower his standards.

Not so, according to the North Carolina study: Generally speaking, the G.P. with an above-average patient load also practiced above-average medicine.

Doctors in rural areas may have scored low because they didn't have access to proper medical facilities.

To quote the report: "A physician presumably enters practice with all that is required for taking a good history and performing a careful physical examination." And he doesn't need a roomful of expensive equipment to run a few basic screening tests. The fact appears to be that many of the surveyed doctors did not make full use of such diagnostic equipment as they had.

Maybe some of the surveyed men jacked up their usual performance because they were being observed.

It's possible. Yet, as the researchers say, "It is difficult abruptly

couldn't figure out why these men did certain things. Some of them had evidently never had the basic training needed for the practice of good medicine. Others knew better, but didn't seem to care enough.

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Some of the research team's standards for judging competence may seem overly stringent. But the significant question

isn't really whether or not the grades were too low. It's whether the ratings were relatively sound. This they probably were. The observers' painstaking methods of systematizing their judgments left little room for erratic or hasty conclusions.

Chances are, you can't be quite so systematic or impartial in measuring your own perform-

to change established habits and reaction patterns and even less likely that alterations could be consistently maintained for the three- or four-day period during which observations were carried out." Incidentally, no one told the men their clinical performance was being graded; but some of them guessed it.

Usually, the family doctor doesn't need to take an involved history: He's already well acquainted with most of his patients and their families.

When a G.P. sees an average of thirty patients a day, as these men did, he can't possibly remember everything about everybody. Unfortunately, he's sometimes more likely to remember that Mr. Smith's brother-in-law is a carpenter than that Mr. Smith once had shingles. An example of such medical forgetfulness: One surveyed doctor's patient had a large surgical scar on his abdomen. The doctor knew he'd referred the man to a medical center a few months before. But he couldn't remember what for—and he had no idea what operation had been done.

#### HOW DO GOOD DOCTORS GET THAT WAY?

ance. But, from the examples given here, you can get an idea of how your practice methods would appear to an outsider. First of all, then, let's consider:

### The Medical History

You belong with the minority -a very small but elite groupif you customarily take a thorough history.

Something under 10 percent of the North Carolina G.P.s showed up well on history-taking. They were the men who asked their patients questions that showed they had thought of all the diseases

and complications that might possibly relate to a specific complaint. In addition, they asked methodically about symptoms in all the major organ systems and delved into the medical history of the patient and his family. The observers also felt these doctors showed considerable clinical knowledge and interviewing skill.

Thirty per cent of the G.P.s turned in adequate but not outstanding performances. Though they did almost everything the first group did, they seemed to be less painstaking. They asked fewer questions, took less complete

#### CRITICAL SIDELIGHTS (Cont.)

If a G.P. 18 inclined to forget, he should keep better records rather than go over the same ground every time a given patient comes in.

True enough. But the men who scored badly on history taking were generally the very ones who kept skimpy records.

You can't judge a physical examination by overt acts alone.

That's admittedly a weakness in any study of this sort. The observers tried to compensate for it by asking questions about the G.P.'s thinking and observations. But there wasn't always time for either question or answer.

histories, showed less skill at interviewing.

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Finally, low ratings were assigned to 61 per cent of the men. Some of them took no history at all. Others asked only about the patient's complaint or about the part of the body involved. They tended to ask rambling, unrelated questions that showed little thought or clinical knowledge.

None of the eighty-eight G.P.s took a planned psychiatric history. Many of them complained to an observer that their schooling had given them no groundwork for dealing with emotional problems. While most of the doctors recognized such problems in an occasional patient, few tried to do anything about them.

## Physical Examination

If you do head-to-toe physicals on new patients and on old patients you haven't seen in some time, apparently you're again among the select few. The observers found that such physicals were the exception rather than the rule among the North Carolina G.P.s.

So the doctors had to be graded chiefly on [MORE ON 304]

The typical G.P. does a lot of surgery and obstetrics. Yet these weren't included in the study.

They weren't included because the research team (composed mainly of internists) didn't feel competent to judge specialized techniques in these fields. Besides, surgery and obstetrics are not all-important in the average general practice. (During the study period, fewer than 16 per cent of the G.P.s' cases were surgical, fewer than 13 per cent obstetrical. By contrast, 57 per cent of their cases were essentially medical.) Also, the researchers felt that correct diagnosis and good patient management were the real criteria by which to judge a man's handling of any case. END



Take a lesson from these

# 5. THE CASE OF

By Xavier F. Warren

EDITOR'S NOTE: Here is the fifth in a series of true incidents selected from the confidential file of a malpractice insurance company's claims adjuster. Although names and identifying details have been changed, the stories accurately portray recent happenings. Each case highlights the danger of some form of haste or carelessness on the doctor's part.

In a town in my area there was a merry widow named Gloria Brewster. A full-blown blonde in her early thirties, she had a fondness for roadhouses and alcohol. As a result, the whole night shift at the small hospital knew her well. Often she'd be brought into the emergency room to be treated for minor injuries suffered while under the influence.

One night about 3 A.M. she was brought in by a married man with whom she'd been out having her customary brand of fun. On the way from one roadhouse to another, she'd managed to fall out of his car. She had a skinned left knee, a bruised forehead, and several other minor lacerations. The man left her with the nurse in the emergency room and got out of there fast.

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# THE MERRY WIDOW

The nurse telephoned upstairs to Dr. Johnston, the surgical resident. "Herself, the merry widow, is here again," she said. "Drunk, of course, and with the usual cuts and bruises."

"Oh, boy," he sighed. "Better not let her break up any furniture. I'll be right down."

When the doctor arrived, the blonde, sleepily belligerent, sat swaying on a chair. The nurse stood by warily, ready to catch her if she toppled.

Dr. Johnston approached her with a winning smile. "Hello, Mrs. Brewster!" he said. "And how are you doing tonight?"

"And who the hell are you?" inquired Mrs. Brewster.

"It's the doctor," said the nurse.

"You're not gonna take my clothes off, you goddam Peeping Tom!" said Mrs. Brewster. She aimed a kick at the doctor. She missed.

"All right, Mrs. Brewster," he said. "You can keep your clothes on, every stitch. But I'd better bandage your knee."

"Okay, okay," said Mrs. Brewster blearily. "Go ahead."

With the patient mouthing an occasional curse at the

world in general, the doctor treated her cuts and scratches, felt her skull for fractures, and gave her a shot of chlorpromazine. "She'll be all right," he told the nurse. "Just get her to bed and keep her there until she sleeps it off."

"My leg hurts," mumbled Mrs. Brewster.

"Your knee's a little skinned," said the doctor. "It'll feel better tomorrow."

Early the next morning Dr. Johnston looked in on Mrs. Brewster. Her face was pale and puffy. She had her usual morning-after look. Just one thing was not usual: She was dead.

An autopsy revealed that there had been a fracture of the right iliac bone, severing the right common iliac vein. This had resulted in an interabdominal hemorrhage. She had bled to death.

A few weeks later Mrs. Brewster's relatives, acting on behalf of her 12-year-old daughter, sued Dr. Johnston for malpractice. Fortunately for him, he carried insurance with my company. Unfortunately for us, the case was indefensible.

The doctor hadn't been guilty of gross negligence. Under the circumstances there was some excuse for his cursory examination of the patient.

But there wasn't enough of an excuse to keep a jury from blaming him for having allowed a serious injury to go undiscovered and untreated. We had no choice but to make a large settlement out of court.

Other doctors have discovered that an alcoholic patient can be a malpractice booby trap. I suppose it's no fun trying to do a careful examination on a belligerent, abusive, half-conscious drunk. But it's no fun being charged with malpractice, either. END



# What Some M.D.s Think of Closed Panels

One-third of the M.D.s queried have been asked to join; most have declined. But they're more tolerant of such panels than you might expect

By Howard Latane

What's a closed panel? As most doctors think of it, a closed panel is a group of physicians serving patients whose medical care is prepaid and whose choice of doctor is limited to those in the group.

And as many medical leaders think of it, the closed panel is the greatest current threat to independent medical practice.

It's difficult to weigh this threat nationally. It's difficult even to find out exactly how many such panels now exist. But signs are that at least 175 of them serve some 3,000,000 subscribers. About two-thirds of this enrollment is in the Middle Atlantic and West Coast states. The rest is scattered through every region of the nation.

Nationally speaking, then, the closed-panel menace may seem an uncertain threat to many doctors. But it's growing. Only recently, the United Automobile Workers union revealed it was considering a colossal plan for

#### WHAT SOME M.D.S THINK OF CLOSED PANELS

Michigan.\* And the A.F.L.-C.I.O. in Colorado is reportedly pondering a big new panel there.

What's been the impact of closed-panel plans on private practice in areas where such plans are well established? An answer to this would obviously help doctors elsewhere to decide how much of a threat the closed

panels might turn into. And one place to look for an answer is New York City. Myriad panels have flourished there in the past ten years.

So MEDICAL ECONOMICS has questioned a representative cross-section of the 11,000 M.D.s in New York's five boroughs as to (1) their experience with, and (2) their attitude toward closed panels. [MORE]

\*See "Is Reuther Bluffing Medicine?" MEDICAL ECONOMICS, March, 1957.



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#### CLOSED PANELS

The doctors were not asked obviously leading questions. They weren't, for example, asked whether they'd lost patients to closed panels (which might easily have brought out more vindictive comment). Instead, all questions were phrased as objectively as possible. For instance:

"Have you ever been asked to join a closed panel?" . . . "What were your reasons for joining a panel?" . . . "If you refused to join, what were your reasons?" . . "What is your opinion of panel practice from the doctor's point of view?"

One out of every twenty New York physicians-550 in allanswered the questionnaire. In addition, MEDICAL ECONOMICS interviewed personally a number of men who expressed special interest. Here's what was learned:

New York City doctors apparently do not see closed-panel practice as a big threat to independent practice. Only twentyfive respondents said they considered it so. Only two volunteered the information that they'd actually lost patients to the plans.

In view of the repeated warnings of medical leaders, the above findings seem more than unexpected. They're startling.

The survey does show that two out of three New York doctors

are opposed to closed-panel practice—mostly on the ground that it's inefficient or unethical. And two-thirds of these opponents appear to base their opinions on extremely limited observation of the plans. For example, of the forty-four physicians who complain that the panels' remuneration is too low, only four have ever worked with one.

In short, such objections to closed-panel practice as the survey turned up seem quite often to be based on hearsay.

The relationship of all the surveyed doctors to the panels adds up this way:

8.9 per cent now belong to a closed panel.

4.4 per cent once belonged but have quit.

22.3 per cent have been asked to join but have refused.

64.4 per cent have had no personal contact with the panels.

Let's examine in some detail what doctors in each of the above categories have to say about closed-panel medicine.

## **Present Panel Members**

Three out of four of the respondents who now belong to a panel say they are satisfied with the arrangement. Most of them



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#### WHAT SOME M.D.S THINK OF CLOSED PANELS

joined for economic reasons, attracted by assured income, pensions, and other benefits. Many younger men seem to view panel practice as a convenient way to get experience and to build their own private practices. Older men say it keeps their income up at a time of reduced earning-power.

A number of respondents contend that, apart from its economic benefits to the doctor, the closed-panel plan is the best means of giving low-income patients full medical care.

Only a fifth of the panelists give all their time to a plan. These

men see an average of seventeen patients a day. Their average income appears to equal that of similar men in independent medical practice.

The part-time panelists average six patients daily. About 20 per cent of their total income derives from panel practice.

On the average, the panel members have been with their groups for seven years. Two-thirds of them are with the Health Insurance Plan of Greater New York (H.I.P.), composed of some thirty individually administered panels, with a total of



500,000 subscribers. The remainder are scattered among panel plans serving perhaps 200,000 other subscribers in unions, fraternal organizations, etc.

Younger men seem to be the ones most satisfied with panel practice. "It's an excellent way to learn medicine in a clinic atmosphere," comments a 32-year-old internist who's a part-time panelist for a butchers' union.

Another young internist, who's been with H.I.P. part-time for a year, claims: "You can practice first-class medicine in this set-up. It's wonderful to be

able to refer patients for consultation any time you want, with excellent lab and X-ray facilities available, without worrying about what it'll cost the patient ... Exploitation of the doctor by the patient is very uncommon. And good rapport with patients comes as easily as in private practice. It just takes a little longer."

"Closed panel isn't the dirty word organized medicine tries to make it," adds an older man—a 54-year-old radiologist who's been a part-time H.I.P. panelist since 1948. "No patient has to join a group plan. He does so

# dosage

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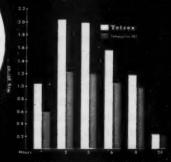
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# Twin benefits in peptic ulcer therapy

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(Tricyclamol Chloride, Lilly)

# reduces gastric secretion and gastro-intestinal motility

Because 'Elorine Chloride' is capable of reducing gastric secretion and decreasing the motility of the gastro-intestinal tract (except the esophagus), it is especially valuable in the management of peptic ulcer. Other indications for 'Elorine Chloride' are functional digestive disorders, acute pancreatitis, diverticulitis, pylorospasm, and excessive sweating.

## Effective in peptic ulcer therapy

In a comprehensive study of anticholinergic agents, Sun and Shay¹ investigated the effect of a single "optimal effective dose" (O.E.D.) on basal gastric secretion. Under study were twenty-two patients with chronic duodenal ulcers which were secreting acid gastric juice continuously. The patients also received isotonic sodium chloride solution to rule out psychogenic factors. All drugs were administered intraduodenally. Results showed that 'Elorine Sulfate'\* produced a "pronounced and significant" decrease in mean gastric volume, free and total acid, and pepsin output.

## Longer suppression of gastric acidity

Duration of suppression of acidity was measured in sixteen patients. 'Elorine Sulfate' reduced gastric acidity to ph 4.5 or higher in all sixteen patients. This reduction was maintained from 30 to more than 270 minutes. In nine of the sixteen patients it lasted longer than three hours. The O.E.D. for 'Elorine Sulfate' varied from 150 to 500 mg.; this emphasizes the need for individual dosing.

<sup>\*</sup>The 'Elorine Sulfate' (Tricyclamol Sulfate, Lilly) used in this study is therapeutically identical with 'Elorine Chloride' now available.

### Decreases basal secretion in emotional stress

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In another phase of their investigation, Sun and Shay studied the effect of 'Elorine Sulfate' on gastric secretion stimulated by emotional stress.

One hour's basal secretion was collected. A disturbing thirty-minute interview based on a previously determined conflict was then conducted by a psychiatrist. Control basal secretion and secretion after emotional stress and after emotional stress plus 'Elorine Sulfate' intraduodenally were plotted.

In the stress situation without 'Elorine Sulfate,' an initial depression of gastric secretion was followed by a 700 percent increase in mean basal secretion during the third and fourth peak hours. The administration of 'Elorine Sulfate,' on the other hand, inhibited gastric secretion throughout the four-hour period following the interview.

## Dosage must be tailored to the patient

An effective dosage for the inhibition of gastric secretion varies greatly from one patient to the next. Thus, it cannot be administered according to body weight or in any recommended uniform dose. Dosage should be tailored to the patient's tolerance.

In peptic ulcer, the average adult dose ranges from 100 to 250 mg. three or four times daily.

'Elorine Chloride' is available in pulvules of 50 and 100 mg. at pharmacies everywhere.

## Achieving added sedative effect

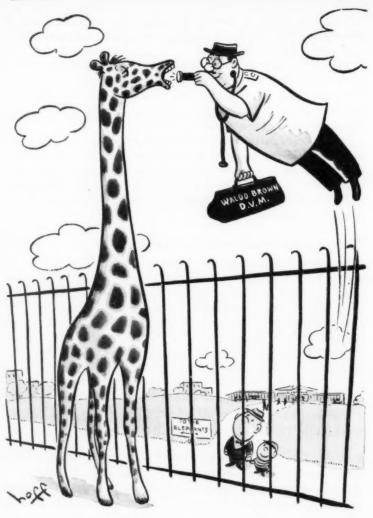
For anticholinergic action plus a quieting effect, prescribe 'Co-Elorine' (Tricyclamol Chloride and Amobarbital, Lilly).

Pulvules 'Co-Elorine' 25 contain 25 mg. 'Elorine Chloride' and 8 mg. 'Amytal' (Amobarbital, Lilly).

Pulvules 'Co-Elorine' 100 contain 100 mg. 'Elorine Chloride' and 16 mg. 'Amytal.'

1. Sun, D. C. H., and Shay, H.: A.M.A. Arch. Int. Med., 97:442, 1956.

Ziley ELI LILLY AND COMPANY . INDIANAPOLIS 6, INDIANA, U.S.A.



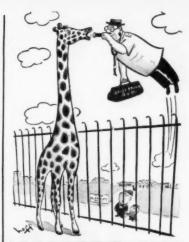
Give your patient that extra lift with "Beminal" Forte 817

#### CLOSED PANELS

voluntarily because he gets berter coverage and better medicine. Until I'm retired at 65, I can practice medicine ideally—without cutting corners to avoid expense to the patient. It's a most pleasant arrangement. Future medicine is going to be group medicine."

Other panelists don't speak so glowingly. "There's been a lot of politics, with merit as a secondary consideration," says a 40year-old urologist who has seven years of panel experience and is currently a part-time member of two groups. "Most of the older surgeons I've seen in group medicine haven't expended any great effort to boost younger surgeons." But on the whole, he adds, "the low-income people covered couldn't get medical care of such quality without closed panels."

Agreeing with this last remark is a 50-year-old G.P. who's a partner in a H.I.P. group. "I've had much experience both with independent practice and with H.I.P.," he comments. "I believe the medical care the closed-panel patient gets is in general every bit as good as that given him under other arrangements. Before I went into panel practice I was very much opposed to it. I went in actually looking for the bad



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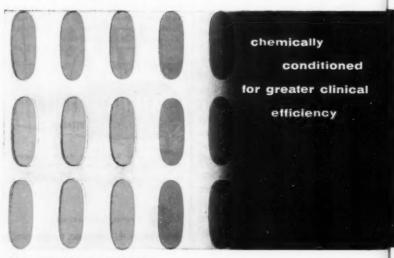
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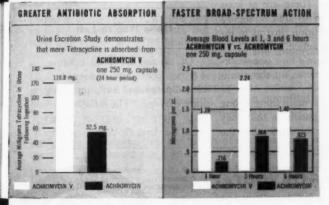
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#### WHAT SOME M.D.S THINK OF CLOSED PANELS

things. But I've found more good things than bad."

He feels it's unfair to say that H.I.P. patients are deprived of free choice of physician. "If they prefer doctors in another group," he points out, "they can change at any time. There are at least four groups in my area. So there's really competition, just as in independent practice."

Finally, here's how one working panelist sums up the situation:

"I'd say the main thing wrong with closed panels is that they aren't very much better than the average independent practitioner. But from the patient's standpoint, even bad group practice is preferable to the average solo practice. Two heads are better than one, especially in medicine."

#### Those Who've Left

Of all the surveyed doctors, 4.4 per cent once belonged to closed panels but have quit. Why have they quit? The reasons most often given are, in order: Panel work burdens the physician with

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Naturally not. Missing calibration makes it worthless.

Equally useless and dangerous is a "quantitative" urine-sugar test that does not quantitate dependably, or omits readings in the critical range.

Enzyme urine-sugar tests are sensitive and specific for glucose–excellent "yes" or "no" tests but undependable for quantitation. King and Hainline,¹ after testing 1,000 urines, found an enzymatic urine-sugar test unable to distinguish in the important range between ½ per cent and 2 per cent or more of urinary glucose. Leonards,² in a report on 4,020 tests, revealed that "... in 502 out of 804 tests the wrong interpretation was made." He concluded that enzymatic urine-sugar testing "... as a quantitative procedure is unsatisfactory and can lead to serious error in the interpretation of a patient's clinical condition."

Failure to recognize this limitation of enzyme tests may result in incorrect insulin dosage,<sup>2</sup> and may lead to diabetic complications.

(1) King, J. W., and Hainline, A., Jr.: Commercial Glucose Oxidase Preparations for the Detection of Glucose in Urine, Cleveland Clin. Quart. 23:212, 1956. (2) Leonards, J. R.: Evaluation of Enzyme Tests for Urinary Glucose, J.A.M.A. 163:260 (Jan. 26) 1957.

reliable readings throughout the critical range—does not omit  $\frac{34}{2}$  (+++) and  $\frac{1}{2}$  (++++)

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#### CLOSED PANELS

too many and too demanding patients; it doesn't pay well; it isn't as efficient as it's cracked up to be.

"It turned out to be exploitation par excellence," says a 58year-old general practitioner, a H.I.P. panelist from 1950 to 1953. "There were night and Sunday calls, many more patients than I'd been led to expect, and no extra remuneration."

Adds a 43-year-old G.P. who left a \$14,000 salaried job with H.I.P. after six years: "Medical care became more and more inferior because those in control insisted on cutting corners to make money. I know nothing about any other group. But this one was a form of medical prostitution."

"The attitude of H.I.P. that the customer is always right was hard to take," complains another former panelist. "And our particular group was run in a highhanded manner, with no regard for the doctor."

Yet a third of the respondents who've left closed panels seem to have done so with no hard feelings. Says one such man:

"Though I did quit a group, I'm still in favor of closed panels. They give some financial security to the doctor, unlike the A.M.A's complete disregard for



#### WHAT SOME M.D.S THINK OF CLOSED PANELS

the physician's social security. And they eliminate the annoying problem of fee between doctor and patient."

Those Who Wouldn't Join

Two out of every nine of the surveyed physicians—or 22.3 per cent-have refused offers from one or another of the closed-panel plans.

They've apparently done so chiefly because they feel that closed-panel medicine restricts free choice of doctor and makes the physician answerable to lay authority. But some of them have had other [MORE ON 294]

# Thanks Anyway

It was 3 A.M. The bedside telephone rang.

"Doctor," a woman said, "I realize you were probably. asleep, but we've got an awful sick boy out here."

"What's the name?"

"Sammy. He's been moaning and going on something terrible."

"Yes, but I mean your family name."

"Oh; sure! The name is Henderson."

"All right. Now, where do you live?"

"Where do we live?"

"Well, let me put it this way: Where is your house located?"

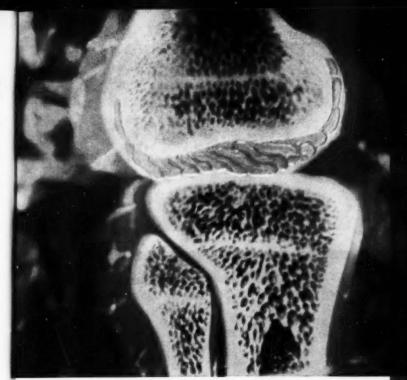
"Oh! You go two miles west of town to the junction. Then you turn north on the dirt road for three miles, then west three miles. That's where the crossroads are, you know. Then . . . Hold on, Doctor. My husband's trying to tell me something."

There was mumbling at the other end of the line. Then the woman came back on:

"Never mind, Doctor," she said. "Sammy isn't sick after all. It was just a bad dream my husband had. Thanks anyway! Good-by!" -H. GLENN CARSON

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# How You'll Use TV in Your Practice

This forecast may sound like science fiction—but it isn't. It's a physician's analysis of medical electronic marvels that already exist

By Frank Z. Warren, M.D.

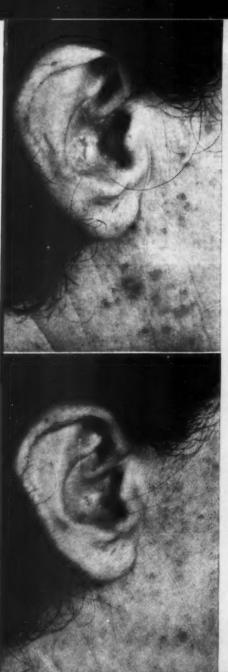
"Dr. Jones! Wanted in TV Control! Dr. Jones!"

In Building C of the medical center, Dr. Jones walks to a corridor booth. Inside, he presses a button below the TV screen and announces himself to TV Control. A moment later a nurse's face appears on the screen.

"It's Mrs. Wilson in Ward 47, Doctor," she says. "Blood-transfusion reaction."

Almost immediately, the screen shows him a panoramic color view of Ward 47 in Building N, half a mile away. The doctor fiddles with a knob, and the far-off camera pans slowly around the ward. He stops it at Mrs.

THE AUTHOR is TV Director of the New York State Society of Anesthesiologists and TV consultant to the Kansas Unicersity Medical Center. He has produced and directed many medical television programs—among them the first scrambled-image telecast and the first three-camera color program on medical subjects. He's the author of the A.M.A. handbook "Television in Medical Education." He's also attending anesthesiologist at Brooklyn's Methodist Hospital.



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■ Before local application of 'PRAGMATAR'. Seborrheic dermatitis of long standing, with typical yellowish, greasy scales along hairline and external auditory canal.

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# Pragmatar\*

Smith, Kline & French Laboratories, Philadelphia 1 Wilson's bed, where an interne is standing by.

Now the doctor twists another knob, and the camera-eye zooms in for a close-up. Dr. Jones studies the patient's coloration, breathing, and general condition. He begins to ask questions. The interne hears them and answers them through a two-way built-in speaker behind the bed.

#### Listens to Heart

Then Dr. Jones says: "Stethophone, please."

The interne applies an electrostethophone. Dr. Jones listens

thoughtfully to the magnified heart and lung sounds, then gives instructions and watches the interne carry them out.

After a few cheering words to the patient, the doctor steps out of the booth and continues his rounds. He'll stop over to see Mrs. Wilson as soon as he can. But thanks to electronics, he knows her case is under control. So he doesn't worry about it.

Nor does he give a second thought to the wonder of what's happened. He's so used to TV in medicine he couldn't imagine practicing without it. [MORE]



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#### TV IN YOUR PRACTICE

And why should he? Why should any doctor fifteen or twenty years from today?

The above picture of tomorrow's doctor at work is no pipe dream. Every electronic development needed to make it a reality is already here.

We have the compact and versatile vidicon color camera. We have remote-control equipment that allows a distant operator to swivel the camera and adjust focus. And we have the electronic stethophone, capable of magnifying chest sounds up to 50,000 times.

"Maybe so," you may say.
"But who could afford such things? Just because they're here,



"It's the hospital... they've scheduled your emergency appendectomy for next Tuesday."

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it doesn't follow that they're practical for everyday use."

One answer to that objection materialized just a year ago in the Morristown (N. J.) Memorial Hospital. It's a small-community institution, not an outstandingly rich one. Yet it could afford a closed-circuit television booth in its lobby. It was put there for visitors under 14 (who aren't supposed to visit patients in their rooms).

## TV Delights Kids

Using this booth, the children could see and chat with their hospitalized parents. The kids were delighted at "being on TV." And, naturally, the sight and sound of his child is a tonic for any sick adult.

Other hospitals are installing similar morale-builders. The surprisingly low cost: about \$2,500.

That's a modest harbinger of things to come. And this much is already clear: Though medical television is still a financial ortechnical impossibility for most small-community and individual uses, it's becoming less impossible every year.

With today's electronic developments in mind, therefore, let's see what you can logically expect

during the next couple of dec-

First of all, your examining and diagnostic methods will be speeded and improved by a host of electronic assistants. There's telefluoroscopy, for instance. It's already in routine use at Johns Hopkins, Walter Reed, and other great hospitals. The Cleveland (Ohio) Clinic reports that its use has cut heart-catheterization time 20 to 30 per cent and has reduced the amount of X-ray required by one-third.

Then, too, an efficient television camera-tube the size of a walnut has already been perfected. Along with telefluoroscopy, it presages some form of TV-endoscopy for your future daily practice. What you can expect is this:

# 'Sleeping-Pill' Camera

There'll be a tiny camera-tube, no bigger than a sleeping pill, attached to an insulated wire. When your patient swallows the "pill," a magnified color picture of what the camera sees will appear on your office TV screen.

If you're a neurologist, you'll profit from the work now being done at Brookhaven Laboratories and other government research centers. They've made

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Unique physiologic barrier—topical amino acids brings rapid relief (98%1) and complete healing (88%1)

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- (2) accelerate healing, [Hydrolamins rapidly and completely healed reddened, fissured, macerated and ridged perianal lesions in 88% of cases:1]
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 Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18:39 (Feb.) 1951.

 Fromer, J.L.: Dermatologic Concepts and Management of Pruritus Ani, Am. J. Surg. 90:805 (New.) 1955.

amazing advances in electroencephalography and radioactive deep brain therapy techniques. Probable end result: an electronic cranial helmet that will combine diagnosis and treatment. . .

Strapped to a patient's head, such a helmet will read the brain's electrical waves. It will record abnormalities. And, if necessary, it'll eject "guided missiles" of radioactive material to seek out and destroy the most obscure brain tumor.

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Fantastic? No more so than the electronic hemocytometera device that's already being used at Manhattan's Sloan-Kettering Institute: It can do a blood count in one-thirtieth of a second.

You can expect a refinement of it for individual office use. You can also expect your sanguinometer to analyze, interpret, and report blood-test findings in conditions such as the leukemias. And you can expect to get a permanent "visi-report" record of the results by means of a tapefilm attachment.

Very soon, finally, you'll be using words like ballistographoscopy, electrosonography and similar electronic tongue-twist-

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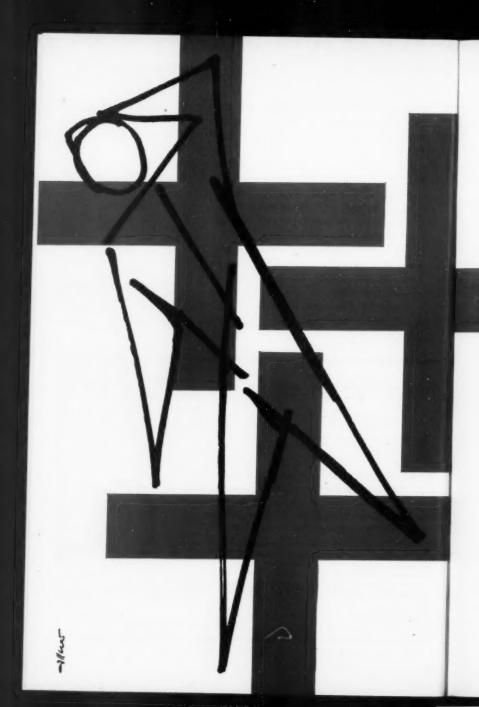
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#### TV IN YOUR PRACTICE

ers. The gadgets they describe will outline and interpret a threedimensional picture of heart, lungs, and other deep-seated organs.

Once such electronic methods have become common office procedure, your diagnoses are likely to be more positive than they are now. One result: Exploratory operations should become a rarity in tomorrow's practice.

It's the specialist, of course, who'll make most use of the advances I've been discussing. They'll naturally affect the G.P. too. But the family doctor's professional life will be most affected by scrambled-image TV.

This is a system that will permit you to sit in your home or



office, before your open-circuit TV set, and watch a medical program for doctors only. A coder (or scrambler) will distort the image at the transmitter. Then your own decoder (or unscrambler) will straighten out the waves at your end.

#### Three Years Old

Scrambled-image TV was demonstrated at the New York Academy of Medicine over three years ago. And it has come a long way since then. Its possibilities for future medical use are headspinning. For example:

You can look forward to a nation-wide network of medical scrambled-image television centers, with special channels for national, state, and local medical programs. And you can anticipate "emergency channels" for doctor-to-hospital and doctor-to-doctor consultations.

Here are some of the resultant services to you and your colleagues all over the country:

¶ Since you'll be able to see programs on your home or office set, you'll have ready access at all times to visual information from medicine's top authorities. You'll even take post-graduate courses that way.

[MORE]



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# New way to reach high C!

New Gerber Strained Apple Juice has a guaranteed high vitamin-C value—40mg. of crystalline ascorbic acid added per 100 c.c. Developed as a pleasant nutritional alternate to Gerber Strained Orange Juice, the new Apple Juice can be offered as a reliable source of vitamin C. Good for the baby who has an intolerance to citrus fruit. **Gerber. Strained Apple Juice** 

#### TV IN YOUR PRACTICE

¶ You can attend your local medical society meeting by TV if you can't get there in person.

By means of your office transmitter-receiver, you'll be able to consult with a distant specialist-and to show him everything he could see if he were at hand. In the same way, he can let you know his telefluoroscopic findings, blood-test results, and other visual data pertinent to the case you're treating.

So it goes. Almost every aspect of your professional life is likely to be changed by electronics. The changes will come graduallybut a lot sooner than you think.

Right now, hospitals under construction are making provision for TV conduits and wiring. The Army, Navy, and Public Health Service are expanding their electronic research programs. The Bell Telephone Company is perfecting its visiphone, which adds video to telephone voice transmission. This in itself could revolutionize your consultation habits.

Facts are catching up with fancy. Today's medical marvels will almost certainly be tomorrow's medical routine.

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LOS ANGELES



Local Blue Shield Plans

If you've heard rumors that Blue Shield will be 'going national,' discount them. But something important for the plans—and you—IS happening

By James E. Bryan

Blue Shield is about to achieve some nation-wide uniformity. But don't be alarmed. The independence of your local plan isn't in danger.

For Blue Shield is seeking uniformity only to this extent: Most plans will soon be offering medical-surgical contracts that all have the same basic range of benefits. The doctors who run your local plan will still have the say about income ceilings and schedules of payment.

A uniform range of benefits for Blue Shield throughout the U.S.A. will bring solid benefits to you. It should enable the plans to enroll veritable hordes of new subscribers; and that should mean lower operating costs, increased services, and better payments to doctors.

Up to now, Blue Shield hasn't been able to offer the kind of national group coverage wanted by some of the huge, industry-wide labor unions and interstate corporations. So the doctors' plans have been losing thousands of

THE AUTHOR, a former administrator of the New Jersey Rlue Shield plan, is a consultant in medical administration and prepay medical care.

### Meet a National Challenge

ns

potential customers and the commercial companies have been picking them up.

Nor could Blue Shield do much about the problem as long as sixty-six stanchly independent U.S. plans insisted on endless variations in their contract provisions. As every doctor knows, physician-sponsored health insurance has developed strictly locally. There's never been a national organization with power to bring individual plans to heel. Nor has anyone seriously urged it.

The Blue Shield Commission in Chicago sounds authoritative enough. But it gets its policies from the member plans—and they in turn are controlled essentially by their sponsoring medical societies. The Commission, as the Board of Directors of "Blue Shield Medical Care Plans," administers the membership standards, coordinates national publicity, gathers statistics, and is generally helpful to the plans.

Local autonomy is a basic tenet of Blue Shield philosophy. Trouble is, such autonomy gets in the way whenever some big outfit operating in several states wants a single, clear-cut medical-surgical contract for all its members. Outside any single plan area, there's been no agreement on what Blue Shield benefits are.

At present, the best Blue Shield can offer such clients is a "syndicate" scheme. Stated simply, this works as follows:



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### BLUE SHIELD'S CHALLENGE

The local plan in the headquarters area of the union or company to be covered writes the contract under its usual terms. Then, as the "home" plan, it invites local plans elsewhere to underwrite similar contracts for the client's members there.

### **Home Plan Collects**

The differences in subscriber charges among the participating plans are leveled off by charging the interstate client an average rate. The home plan collects the total and pays each plan at its individual rate.

If some of the plans can't or won't offer some of the benefits covered by the home plan's contract, such "excess" benefits may be extended by an organization known as Medical Indemnity of America, M.I.A. is a stock insurance company with headquarters in Chicago. It's entirely owned and operated by the Blue Shield plans. Its chief function is to take care of gaps in syndicate coverage (although in some cases it has directly underwritten interstate accounts, such as Procter & Gamble).

Theoretically, the syndicate scheme ought to work pretty well. But too often the final contract offered the client is a hodge-podge of adjustments, sub-un-

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#### BLUE SHIELD MEETS A CHALLENGE

derwritings, special clauses, and what-have-yous. And when a large national union or corporation buys medical-surgical coverage, it doesn't expect to get a crazy quilt for its money.

### The Big Boggle

Lots of big accounts have made it clear they'd rather do business with nonprofit, doctorrun Blue Shield than with a commercial company. Yet they've boggled at the syndicate complexities.

That's one prime reason why, in the recent past, Blue Shield has lost such plums as Sears, Roebuck and a large railroad workers' union.

It was to meet this challenge head-on that Blue Shield's medical leaders determined to "nationalize" Blue Shield benefits. About two years ago, a committee of physicians and lay plan executives got to work on the problem. Here's the story of how they tackled it—and apparently licked it:

First the committee set out to find some sort of *pattern* of benefits already offered by the plans. Nobody had ever looked for such similarities before. It seemed a good approach.

But almost at once disillusionment set in: It became clear there was no pattern.

The variations in basic benefits, the committee found, were even more chaotic than had been suspected. Some plans offered no coverage for nonsurgical services in the hospital; others offered a great deal. Some plans covered diagnostic and therapeutic X-ray services plus pathology; others covered one or two or none of the three services. Some plans wouldn't pay for nonemergency surgery if done outside a hospital; others would.

Besides such basic differences, the committee came on a teeming wonderland of minor variations. Some plans featured medical services in the hospital from the day of admission. Others excluded the first three days, or four, or seven. Some allowed full medical benefits for 120 days, some for seventy, others for thirty or twenty-one.

### Wait for Baby!

Some plans made a baby eligible for all medical and surgical benefits at birth. Others made the little guy wait till he was a week old, or a month, or three months, or a year.

[MORE]

## IN TOPICAL INFECTIONS

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#### BLUE SHIELD MEETS A CHALLENGE

"What Blue Shield had been attempting was to put the cart before the horse," says one doctormember of the committee. "We'd tried to work out a national sales program—without any national product to sell. It was as if General Mills tried to do a national business while each of its local plants made cake-mixes by its own formulas."

So, since the committee could not find a pattern of common benefits, it proceeded to create one. It worked out a model Blue

Shield contract that included the basic medical-surgical benefits the committee doctors felt any such contract should contain. This was then submitted to all sixty-six U.S. plans. And at a special meeting in August, 1955, the plans' executive directors unanimously agreed to recommend approval to their governing boards.

At this writing, forty-eight of the plans' governing boards have okayed the model contract. Among the eighteen others, only



"I want a house call at exactly 6 P.M. sharp."

# CAFERGOT



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of ve ct. minor points are still under discussion.

The new program allows local plans to keep their old-style cakemix if they wish. The uniform recipe is for interstate contracts only. But any local plan may adopt the national pattern as its own-and most plans probably will do so.

The big differences between the new program and the present syndicate method of handling interstate contracts are these: (1) Each local plan will be the "home" plan for members of the interstate account in its area, and (2) the scope of benefits will be fundamentally the same in all locales.

The latter is what Blue Shield's big potential customers seem to want most. They're apparently willing to accept all other local deviations for the time being.

#### It's Still Local

That means that neither the customer nor the national association of Blue Shield plans is going to dictate your fee schedule or the income ceilings for service benefits in your state (if yours is a service plan). Such matters are still to be settled by the local doctors whom they chiefly concern.

Here, then, are the basic benefits the model contract would guarantee to all subscribers, no matter where they live:

Surgery, whether in or out of a hospital. (However, there's a small list of surgical procedures -e.g., fulguration of wartsthat may be excluded under any local plan for coverage out-ofhospital.)

Obstetrical services, in or out of hospital, including normal care of the newborn infant. (Prenatal care doesn't have to be included.)

Care of the newborn from date of birth (separately from normal care under the obstetrical benefit. and including all services not generally excluded under the contract).

Medical services in hospital from date of admission-with payment to the physician on a per diem basis for the same number of days as hospital care is covered under the terms of the local Blue Cross contract.

General anesthesia service in connection with an eligible "main service," in or out of hospital, when rendered by a physician anesthetist who customarily bills for his services.

X-ray services, diagnostic or

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Tolerance to this combination is good because there is little likelihood of sodium retention, potassium depletion or gastric distress with buffered predniso-lone, and meprobamate rarely produces significant side effects in therapeutic dosage.

An additional important therapeutic benefit, often overlooked, stems from the tranquilizing action of meprobamate. This component of MEPROLONE relieves mental tension and anxiety so often manifest in arthritics, making them more amenable to other rehabilitation mea-

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arthritis, rheumatoid spondylitis (Marie-Strümpell disease), Still's disease, psoriatic arthritis, osteoarthritis, bursitis, synovitis, tenosynovitis, myositis, fibrositis, fibromyositis, neuritis, acute myositis, fibrositis, noromyositis, neuritis, acute and chronic low back pais, acute and chronic primary and secondary fibrositis and torticollis, intractable asthma, respiratory allergies, allergic and inflammatory eye and skin disorders (as maintenance therapy in disseminated lupus erythematosus, periarteritis nodosa, dermatomyositis and scleroderma).

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#### BLUE SHIELD MEETS A CHALLENGE

therapeutic, in or out of hospital, when rendered by a doctor who customarily bills for such services.

Professional laboratory interpretations, in or out of hospital, when rendered by a doctor who customarily bills for such services.

Physical therapy, in hospital, when administered by a doctor who customarily bills for such services.

It hasn't been easy for the physicians on the plans' governing boards to agree on some of these benefits. The fact that they have agreed is a good omen for the future. It means that the men who run your health plans are resolved to find ways of doing the job Blue Shield was intended to do.

If Blue Shield can get—and hold—a good share of the blue-chip business it's been losing, it'll be in a strongenough financial position to risk turning to an even greater objective: an offer of well-rounded coverage at favorable rates to the self-employed, to farmers, and to many other categories of people now underinsured.





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### 'Call a Consultant

It's such good malpractice protection to insist on consultation that some medical men advise paying for it yourself if need be. Here's why

By John R. Lindsey

A Midwestern attorney who has defended hundreds of doctors in malpractice actions told me this story recently:

He was reviewing the facts in a certain malpractice case with the defendant. Suddenly the doctor interrupted him in the middle of a sentence. "There! Right at that point!" he exclaimed. "That's when I should have insisted on consulting with another physician. The fact is, I did suggest it, but..."

Tho doctor didn't finish his sentence. But the lawyer knew the rest of it by heart. "It's a thought that occurs too late to too many physicians," he told me. "They remember that they suggested consultation but that they didn't press the idea. Now they wish they'd insisted on it. If they had, they might never have been sued."

On the basis of talks I've had with a good many lawyers and doctors, I'm convinced that the physician stands to gain twice if he insists on consultation in a difficult case: (1) He thereby encourages the patient's belief that everything possible is being done for him. (2) He

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thereby engages a strong witness on his side if anything untoward occurs.

The late medicolegal authority, Dr. Louis J. Regan, once pointed out that few malpractice actions are lost on trial whenever an independent consultant testifies to having examined the patient during the critical period. The mere fact that a specialist was consulted, he explained, is an indication that the patient was well cared for.

Court decisions bear this out. So you'll be well advised to protect yourself by insisting on consultation in any of the following four situations at least:

1. Call a consultant if you suspect that the case—or any aspect of it—is beyond your knowledge and experience . . .

A few years ago, a North Dakota physician was sued by a patient whom he'd treated for a spiral fracture of the tibia and a rough transverse fracture of the fibula of the left leg. Over a period of five months, the doctor had maintained that the leg was "coming along fine." He hadn't advised the patient to consult a specialist, nor had he called one in on his own. But the leg didn't "come along fine."

In finding this practitioner liable, the court publicly censured him as follows:

"He must have known . . . [but] he did not inform the plaintiff of the seriousness of the situation . . . Neither did he inform him as to another method of treatment that was accessible and within easy reach. According to the evidence, the defendant recognized . . . that the situation required the services of a specialist, but he never called this to the attention of the plaintiff."

### If Progress Is Slow

2. Call a consultant if the patient doesn't do well (no matter what the reason), even though you're certain your treatment is correct. . .

An ophthalmologist was sued by a man who'd lost the sight of both eyes following a long course of treatment. In court, the physician-defendant clearly established that he'd given the patient all possible care, including complete clinical and laboratory tests. In addition, the ophthalmologist pointed out that he'd based his course of treatment on consultations with a neurologist and another eye specialist. Both these men were called to the witness stand.

Blindness is naturally viewed with extreme sympathy by most

jurors. Yet in this case the jury found for the doctor. Why? Because of the supporting testimony of the consultants.

3. Call a consultant in difficult fracture cases . . .

Some years ago, a G.P. who'd treated an elbow fracture for an out-of-town child was sued on the ground that he'd failed to make a reduction that restored the proper carrying angle.

Actually, though, he had taken all accepted precautions, including X-rays. And he'd shown his pictures to two orthopedic specialists and a radiologist, all of whom had agreed he'd made a good reduction.

The child had left town with his arm in cast, and his hometown family doctor had taken over the case. Upon removing the cast, this man discovered a deformity that required correction. So suit was brought against the first physician.

The jury returned a unanimous verdict in his favor. Once more, it was the testimony of the defendant's expert consultants that apparently tipped the scales.

4. Call a consultant in cases involving pelvic or abdominal surgery in female patients of childbearing age . . .

## Vioform'-Hydrocortisone

Gream in this skin disorder, and many more





In just 7 days, clearing of SOAP-AND-WATER ECZEMA

AFTER



Supplied: Vioform-Hydrocortisone Cream, containing iodochlorhydroxyquin U.S.P. 3% and hydrocortisone (free alcohol) U.S.P. 1% in a water-washable base; tubes of 5 and 20 Gm.

CIBA

SUMMIT, N. J.

VIOFORM® (iodochlorhydroxyquin U.S.P. CIBA)

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In one metropolitan area, eight recent actions were brought following elective pelvic surgery where nothing was found except normal pregnancy. That's one danger to be avoided. For another, consider the following recent case:

### He Looked for Trouble

After delivering a woman by Caesarean section, an obstetrician discovered a cyst in her vaginal wall. Without seeking consultation, he operated and removed the cyst. Later examination by another doctor revealed a vesicovaginal fistula that had gone unnoticed. As a result, several operations and a series of expensive consultations were required before the fistula was closed.

### The Doctor Paid Too

The obstetrician was sued. And he had to settle the case out of court at considerable expense.

The moral seems plain: If he had sought consultation before operating on the cyst, later surgery might not have been necessary. Or, if it had been necessary, he'd have been on firmer ground in fighting any suit.

Consultation is such good pro-

tection for the doctor who must defend himself against malpractice charges that some authorities feel you ought to get it (in any of the above situations, at any rate) even if you have to pay for it yourself. Dr. Regan, for instance, repeatedly made the point that one malpractice suit can well cost a doctor more than a hundred consultants' fees.

### 'You Should Insist'

And while other authorities don't go so far as to urge that one doctor pay another doctor's fee, they do urge that in doubtful cases you *insist* on consultation. Says William F. Martin, chief legal counsel to the Medical Society of the State of New York:

"If you believe consultation is medically advisable, try your best to get it. Try to persuade the patient. But if he positively refuses to consent, don't let it rest there. If he's hospitalized, make a notation on his hospital chart that he refused consultationand do it in front of a nurse or some other reliable witness. If he's an office patient, write him a letter summing up your recommendation and his refusal. And make sure you keep a carbon copy of your letter." END

Under suspicion of anemia

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r e t e

r final

because anemia complicates so many clinical conditions

## TRINSICON.

(Hematinic Concentrate with Intrinsic Factor, Lilly)

2 a day for all treatable anemias



in menorrhagia · in geriatrics · in pregnancy · in adolescence

Lilly
QUALITY / NESEARCH / INTEGRITY

### - serves a vital function in your total therapy

'Trinsicon' provides therapeutic quantities of all known hematinic factors, offers maximum absorption and tolerance.

Just two pulvules daily also produce a standard response in the average uncomplicated case of pernicious anemia and related megaloblastic types.

Daily dose (2 pulvules) of 'Trinsicon' provides:

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor) . 300 mg.

Vitamin B<sub>12</sub> with Intrinsic Factor Concentrate, U.S.P. . . 1 U.S.P. unit (oral)

Vitamin B<sub>12</sub> Activity
Concentrate, N.F. . . . . . . . . . . . . . . 15 mcg

Ferrous Sulfate, Anhydrous . . . . 600 mg.

These three ingredients are clinically equivalent to 1½ U.S.P. units of APA potency.

Equal to over 1 Gm. Ferrous Sulfate, U.S.P.

**note:** Special Liver-Stomach Concentrate, Lilly, supplies, in addition to intrinsic factor, natural compounds that provide broad nutritional support in the treatment of all types of anemia.

In bottles of 60 and 500.

ELI LILLY AND COMPANY . INDIANAPOLIS 6, INDIANA, U.S.A.



## Air-Condition Your Automobile?

Southern doctors are no longer alone in saying it's a good idea. Here's what users around the country report about auto air conditioning

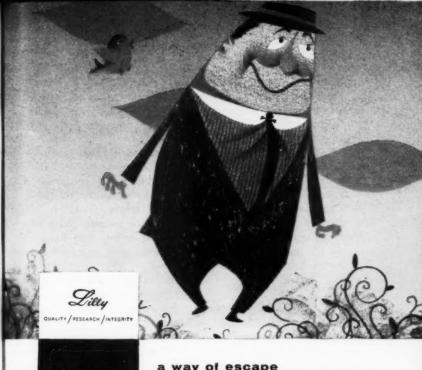
By Clifford Taylor

"I spend two hours a day in my car. I've had auto air conditioning for the past four years. I wouldn't dream of buying another car without it." The speaker: a Texas surgeon.

"The heat's got to bother me a lot more than it does now before I shell out four or five hundred dollars for one more gadget that can go on the blink." The speaker: a New York internist.

How about you? Would you find auto air conditioning worth the price? Until recently, your answer would have depended almost entirely on geography: in the South, yes; in the North, no.

But nowadays more and more Northern doctors are air-conditioning their cars for the sake of cool driving during the dog days of July and August. And they pass on this advice: Don't hold back because you're not sure automobile air conditioning has reached the stage where



a way of escape from allergic effects of pollen

### CO-PYRONIL

(Pyrrobutamine Compound, Lilly)

### -with minimal side-effects

This is the season when we all yearn for escape from everyday life, to "commune with nature." But, to the one allergic to pollen, this craving is usually easier to endure than the penalty of exposure to pollen.

Such a patient is grateful for the relief and protection provided by 'Co-Pyronil.' Frequently, only two or three pulvules daily afford maximal beneficial effects.

'Co-Pyronil' combines the complementary actions of a rapid-acting antihistaminic, a long-acting antihistaminic, and a sympathomimetic.

Supplied: Pulvules, pediatric pulvules, and suspension.

its really practicable. The word is that it works well and that its upkeep is neither troublesome nor costly.

Auto air conditioning has come a long way since 1953, when 20,000 cars were equipped with conditioning units. Last year, installations topped 300,000. Present indications are that at least 450,000 units will be sold this year. Detroit expects the annual sale of units to reach 2,000,000 within four years.

### To Help You Decide

Will you want to be among the buyers? If so, what kind of equipment will you want? Here are the facts to help you decide, as gathered by MEDICAL ECON-OMICS' research department:

1. How good is today's auto air conditioning? Will a system installed now be obsolete in a year or two?

Performance of present conditioners is reported to be excellent. This holds true for both factory-installed and independentlyinstalled systems. Almost any standard unit can produce comfortable driving conditions within six city blocks on a hot day.

Physicians who have air-conditioned cars confirm this. Says a Floridian who drives a 1957 Cadillac with a factory-installed conditioner: "I always lock my car when I park it. Sometimes, when I enter the car again, the temperature has built up to more than 100 degrees. Before I drive three blocks, the air inside is comfortably cool once more."

An anesthesiologist in the same state recently had a unit installed in his 1955 Ford. "I frequently have to leave the car parked for long periods in the sun," he reports. "Sometimes the inside temperature gets up to 130. But within five minutes after I start up, the car's comfortable to drive."

Manufacturers say it's unlikely that the performance of car conditioners will be much improved in the foreseeable future. They may cost less as time goes on, and they may become a bit more compact. But it'll probably be a long time before a 1957 unit can be termed obsolete.

Which means that the equipment you buy today will probably increase the trade-in value of your car tomorrow.

2. Are all types and makes pretty much the same?

There are many minor differences but just two basic types:

Lilly QUALITY / RESEARCH / INTEGRITY

Abates pain and itch, protects against sun's rays

## SURFADIL

(Cyclomethycaine and Thenylovramine, Lilly)

### Formulated to insure patient acceptance

Lotion 'Surfadil' is available in an attractive plastic container (75 cc.) at retail pharmacies everywhere. Also supplied in 1-pint bottles and as a cream in 1-ounce tubes and 1 and 5-pound jars.

Lotion 'Surfadil' combines the highly effective topical anesthetic, 'Surfacaine' (Cyclomethycaine, Lilly); an antihistamine, 'Histadyl' (Thenylphyramine, Lilly); and the protective adsorbent, titanium dioxide. It provides prompt and prolonged relief from contact dermatitis caused by poison ivy, oak, or sumac. It is also valuable for eczema, insect bites, heat rash, and sunburn.

Lotion 'Surfadil' is skin tone in color and virtually odorless; does not readily rub off but washes off easily.

ELI LILLY AND COMPANY . INDIANAPOLIS 6, INDIANA, U.S.A.

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front-mounted units and trunk units.

In the former, all components of the system are under the hood. Directional air outlets are located in or below the instrument panel.

In trunk units, part of the system is under the hood, part in the luggage compartment. Air outlets are in the rear package shelf or in ducts over the doors.

The front-mounted system is cheaper and easier to put in; and it doesn't monopolize storage space. Then, too, it gives rapid delivery of cool air to the front seat, allowing it to be directed to the rear seat when needed.

Trunk units, when coupled with roof duct registers, do a better job of complete coverage on most of the larger cars. But they're not adaptable to station wagons and convertibles.

### What's the Difference?

3. Is there likely to be much difference in performance between factory-installed systems and independently-installed systems?

No. The only big difference is in price. Factory-installed systems cost from \$400 to \$500 for front-mounted units, from \$500 to \$700 for trunk units. Independently-installed systems generally cost less-under \$350 for the front-mounted type, around \$400 for the trunk type.

Automobile manufacturers claim that because their systems are tailored to individual cars, they work better and look less like afterthoughts. The independents argue that their models are preferable for two reasons: (1) They can be mounted in any car, regardless of age; and (2) they can be easily transferred from one car to another.

It's a toss-up, though, where general performance is concerned. On the basis of automotive tests and owner comments. there seems little to choose between the two.

4. How much can you expect to spend annually for maintenance of a car air conditioner?

Generally, maintenance cost is very low. Most independents estimate such expenses at from \$5 to \$10 a year. Auto manufacturers say factory-installed systems cost even less to service.

No matter how you get them, all units carry the usual ninetyday or 4,000-mile automobile warranty. (Some dealers extend the warranty to one year or 12,-000 miles.) And all the systems



for a quick comeback

## V-CILLIN

(Penicillin V, Lilly)

### a powerful therapeutic weapon

Particularly in nonhospitalized patients, no single or combination antibiotic can outperform 'V-Cillin' in eradicating a majority of common infections. Its bactericidal action under clinical conditions generally remains unsurpassed.

### Compares favorably with parenteral therapy

On the basis of total penicillemia, 'V-Cillin' in dosages of 250 mg. t.i.d. is at least equal to a daily I.M. injection of 600,000 units of procaine penicillin G. Therapeutically, these two regimens are comparable.

Safe, pleasant, well tolerated

Supplied: As pulvules of 125 and 250 mg. (200,000 and 400,000 units) and pediatric suspensions of 125 and 250 mg. per 5-cc. teaspoonful.

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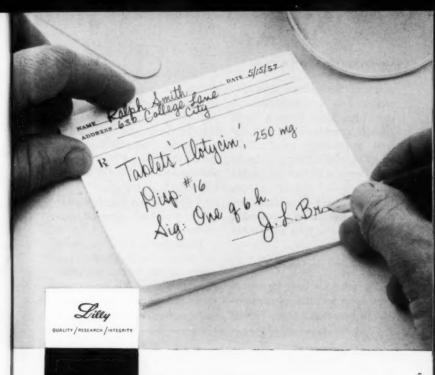
### AIR-CONDITION YOUR CAR?

are intended to last for the lifetime of the car. It's recommended that your air-conditioning system be checked once a year (before the warm weather sets in) for proper refrigerant charge and drive-belt tightness. That's about all it requires.

What if the unit does need servicing? Well, it's easy to get. If you own a factory-installed unit, your car dealer can service the equipment. If it's an independent unit, it can be serviced by any competent refrigeration mechanic.

Of twenty physician-owners of air-conditioned cars queried by MEDICAL ECONOMICS, only one says he's ever had a major repair





when infection strikes the respiratory tract . . .

## ILOTYCIN

(Erythromycin, Lilly)

### provides singularly effective antibiotic therapy because

Dosage: The usual adult dose is 250 mg. every six hours.

Available in specially coated tablets, pediatric suspensions, drops, otic solution, ointments, and I.V. ampoules.

- Virtually all gram-positive organisms are sensitive
- · Allergic reactions following systemic therapy are rare
- Bactericidal action kills susceptible organisms
- · Normal intestinal flora is not appreciably disturbed

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by one oair problem. "Seems my 1955 Oldsmobile with a factory-installed unit just didn't have a large enough generator to carry the load," explains this man, a Texan. "I burned out six batteries in three months before my dealer caught on and installed a new generator. Since it was a new car, the experience didn't cost me a cent. And I've had no trouble since."

### Report Few Headaches

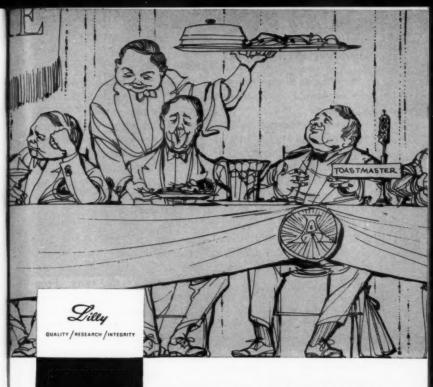
The other nineteen doctors report either no maintenance troubles or very minor ones. Typical of the replies given by doctors is this comment from an Indianapolis ENT man, who drives a 1956 Ford with a locally installed conditioner: "I use it from May through September. No repair or maintenance costs so far, and no flukes."

5. How will an air conditioner affect your car's over-all performance?

According to users, its effects are slight. At the worst, you might get one or two less miles per gallon of gas. Your top speed might be reduced about a mile an hour. Nothing else. [MORE]

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Message.	s amod th	hat the pre	SULT	ng. He	may be
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antipruritic ointment supplied in 1½-oz. tubes and 1-lb. jars, and (liquid) 2-oz. bottles by Thos. LEEMING & Co., INC., New York 17.



relieves after-eating distress
...chronic constipation

## BILRON

(Iron Bile Salts, Lilly)

### a physiological choleretic

Usual dosage: 5 to 10 grains daily with meals.

Available in 2 1/2 and 5grain tasteless pulvules at pharmacies everywhere.

zing jars, 17. ... greatly increases the flow of bile of normal composition. 'Bilron' is acid insoluble and alkali soluble; therefore, it becomes physiologically active in the intestine, where bile is normally released. Gastric irritation is thus averted.

262000

### AIR-CONDITION YOUR CAR?

6. What do doctors who have air-conditioned cars really think about them?

This magazine put the question to men in Dallas, Indianapolis, Miami, and the New York City area. The Northern doctors were less all-out in their endorsement than were their Dallas and Miami colleagues. But not a single one of them—North or South alike—said he'd willingly do without air conditioning in his next car.

### Why They Like It

It isn't always just a matter of pleasanter temperature, evidently. Here are additional reasons why several of the doctors have become stanch advocates of airconditioned driving:

"It helps my hay fever" . .



"It lets me shut out noise and carry on normal conversation with my passengers"... "It's wonderful for my son's eczema, which used to flare up badly during long, hot drives."

The only complaint comes from a Dallas doctor who drives a 1955 Buick with factory-installed trunk equipment: "I don't like the stream of cold air blowing on my neck. But I hear they're designing things better now."

So there's the story. From every angle, it looks as if air conditioning in cars is practical for doctors who do enough hotweather driving to make it worth the rather high price.

### No Need for Pride

At least it's practical enough so that you don't need to be like the Texan who drove up to his home on a blistering day and staggered from his car almost prostrated by the heat. "Whew!" he gasped to his wife. "I thought I'd never get out of that oven."

"Well, for heaven's sake," she said, "why didn't you roll down the windows?"

"What!" he snorted. "And have people think we don't have an air-conditioned car?" END



release from anxiety

## ULTRAN

(Phenaglycodol, Lilly)

### mild, safe tranquilizer

#### anxiety quickly allayed

The patient with vague symptoms, nervous and distressed under the burden of unsolved problems, finds release from anxiety and restoration of emotional composure.

#### mental aculty not impaired

Exhaustive psychological testing shows that recommended dosage does not affect intellectual or motor abilities. 'Ultran' is the first drug for which this has been established by objective and standardized quantitative tests.

#### chemically unique

'Ultran' is a new chemical compound, one of a group of butanediols synthesized at the Lilly Research Laboratories. It is not a modification of any other therapeutic agent.

Dosage: Usually, 1 pulvule t.i.d.

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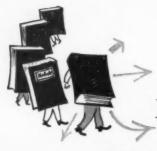
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Supplied: As attractive turquoise-and-white pulvules of 300 mg., in bottles of 100.

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## Your Office Needs

This doctor keeps a supply of ready-mixed answers on a bookshelf to speed up his dispensing of vital information to laymen

By William B. Schafer, M.D.

Some questions patients ask are like fly paper: Once you touch them, you're stuck—and for long enough to wreck your appointment schedule.

If you wish you could find a way to ward off such timeconsuming queries, here's a tip: Try running a small lending library of reading matter for laymen. That's what I do, and it works like a charm.

For years I used to try to cram helpful information into patients while I watched the clock and my reception room bulged at the seams. Sometimes, to bring the discussion to an end, I would recommend a book and would jot down its title. Then one hectic day, when a woman asked a typical "fly-paper" question, I had an idea: Instead of talking at length and recommending a book, why not simply lend her my own copy?

"This will tell you just about everything you need to

THIS ARTICLE has won one of the 1956 MEDICAL ECONOMICS Awards for its author, a pediatrician in Montrose, Calif.

# a Lending Library

know," I said. "Bring it back whenever you're finished."

The woman was delighted. So was I. The loan saved time and trouble for both of us.

Now I keep a selection of reading matter for laymen in my consultation room. It takes up little space. About a dozen books and some fifty pamphlets cover the questions that recur most often in my pediatric practice. Whenever a parent asks one of them, I simply say: "There's a reference book on the subject that I can recommend. Would you like to borrow it for a couple of weeks?" Nobody ever says no.

Such books and pamphlets are especially useful in the field of sex education and parent-child relations. Here are some typical questions that I encounter in this area:

"How should I tell my child about sex?"

(I reach for "Let's Tell the Truth about Sex," by Howard Whitman. It has guidance for children at each age level, plus an excellent bibliography. An alternative is "Facts of Life for Children," put out by the Child Study Association of America.)

"How can I cope with my teen-age son?"

(I hand over the booklet "Understanding Your Adolescent," by J. Roswell Gallagher, M.D., of the Children's Medical Center, Boston.)

"What do I need to do for my premature baby that's



# New Appliances to help solve old problems

Easy-to-Apply, Stays in Place



# LYMPHEDEMA Arm Sleeve

This surgical appliance exhibits good results in cases following radical mastectomy.

Completely adjustable and comfortable to wear, it is loosened and tightened with a lacer. Elastic band prevents sleeve from falling at shoulder... detachable mitten eases laundering. Made for right and left arms in two lengths...which fit most cases.

Remember . . . CAMP authorized dealers have professional fitting services



JACKSON, MICHIGAN

## OFFICE LIBRARY

different from the care of full-term babies?"

(I give her "Young Premature Baby," prepared by the Children's Bureau of the U.S. Department of Health, Education, and Welfare.)

Aside from the books and pamphlets, my only library equipment consists of:

1. A paper pocket, adapted from an ordinary envelope, pasted inside the back cover of each book or pamphlet;

2. A 3" x 5" card, with title and author of the book typed on it, to be kept in the pocket;



Whether you contribute direct to your Alma Mater or your State or County Medical Society or, through the American Medical Education Foundation — Why not DO IT TODAY?

american medical education foundation

535 N. Dearborn Street Chicago 10, III.

This space contributed by the publisher

Three essential steps in establishing correct eating patterns:

SUPERVISION BY THE PHYSICIAN<sup>1,2,3</sup>

A BALANCED EATING PLAN<sup>1,2,3</sup> In the development and
maintenance of good eating
habits, there are three
essentials: support and
supervision by the physician,
a balanced eating plan, and
selective medication. 1.3.3



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# SELECTIVE MEDICATION<sup>1,2,3</sup>

## OBEDRIN PROVIDES:

- · Methamphetamine for its anorexigenic and mood-lifting effects.
- · Pentobarbital as a balancing agent, to guard against excitation.
- Vitamins B1 and B2 plus niacin to supplement the diet.
- · Ascorbic acid to aid in the mobilization of tissue fluids.

Since Obedrin contains no artificial bulk, the hazards of impaction are avoided. The 60-10-70 Basic Plan provides for a balanced food intake, with sufficient protein and roughage.

- Eisfelder, H.W.: Am. Pract. & Dig. Treat. 5:778 (Oct. 1954).
- 2. Freed, S.C.: G.P. 7:63 (1953).
- Sherman, R.J.: Medical Times, 82:107 (Feb. 1954).

# Obedrin

and the 60-10-70 Basic Plan

## FORMULA:

Semoxydrine HCl (Methamphetamine HCl) 5 mg.; Pentobarbital 20 mg.; Ascorbic acid 100 mg.; Thiamine mononitrate 0.5 mg.; Riboflavin 1 mg.; Niacin 5 mg.

Write for 60-10-70 Menu pads, weight charts and clinical supply of Obedrin.

# THE S. E. MASSENGILL COMPANY

BRISTOL, TENNESSEE

NEW YORK . KANSAS CITY .

SAN FRANCISCO

## OFFICE LENDING LIBRARY

- 3. A file box for 3" x 5" cards, with a set of alphabetical guides; and
- A few pieces of cardboard to segregate books and pamphlets on the same subject.

# How I Do It

The lending procedure is simple. I handle it myself, so that it's a personal transaction between doctor and patient. Removing the book's title card from the pocket in the back, I write on it the borrower's name and the date. I jot down also the date I suggest for the book's return;

that varies according to the length of the book. Then I file the card alphabetically by title in the file box. That's all.

The patient stops by the office whenever convenient and returns the book to my secretary. The latter restores the title card to the book pocket and the book to its place on the shelf.

# Bill for 'Lost' Books

I'm not strict about returns. When I need something that's overdue, my secretary phones for it. If a borrower hangs on to a book worth several dollars, I oc-



Hundrede of leading hospitals use Americaine Aerosal as the routine agray-on relief for their obstatrical and gynecological potients. Only Americaine (Aerosal, Dintment, and Liquid) contains 20% dissolved benzecoine in a bland, water-soluble vehicle.

Also useful for burns, sunburn, dermanases, exemitiernas, see-debridement of wounds, cuts, abrasions, etc. to relieve surface pain and itching.

# NEW 3 OZ. SIZE

For individual patient use in hospital and home. Also 5.5 oz. and 11 oz. sizes.

# SPRAY ON FAST RELIEF AMERICAINE ARROSOL

AMERICAINE AEROSOL
For Pulsiful Foot-Epistotomies . . .

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Oynecological Precedures

- Relieves pain in 2-3 minutes
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- Bacteriostatic . . . Senitary
- Quick, easy to apply
- No sensitivity in over 11,800 published cases.

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AMERICAINE AFROSON

ARNAR-STONE LASORATORIES, INC. Mount Prospect, Illinol

THE PICTURE OF COMEORT ALL THROUGH THE PREGNANCY

il sile's blue at breakfast ....

# BONADOXIN

# stops morning sickness

Controlled studies indicate that B NADOXIN relieves symptomsque ly-in 9 of every 10 gravida. Tolerance is excellent.

Prescribe: One tablet at bedtime. Severe cases, one tablet at bedtime, one on a time in tiny pink-and-blue tablets, buttles of 25 and 100. B only.

if she needs
a nutritional buildup—<u>and</u>
freedom from leg cramps†

prescribe STORCAVI

Phosphate-free calcium, iron, 10 essential vitamins, 8 important in herals.

Usually 3 tablets daily, with meals in bottles of 100.

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## OFFICE LENDING LIBRARY

casionally send a bill for it, as for any other service. An inexpensive pamphlet, I just forget—and order another copy.

# Pamphlets Invaluable

Good pamphlets have a value out of proportion to their cost. Most that I use are priced between 10 cents and 60 cents. But the hardest-working titles in my library include some free pamphlets from the American Social Hygiene Association, such as "Your Child's Questions—How to Answer Them" and "Know Your Daughter" and "Know

Your Son." Free booklets on accident prevention from the Prudential Insurance Company and the Metropolitan Life Insurance Company are also well received.

In every practice there are problems the physician meets with patient after patient. Literature for laymen can spare him some of these repetitions. The orthopedist can lend a pictorial book on posture and exercises; the internist, books about chronic diseases or diet; the surgeon, a booklet on convalescent care in the home; the obstetrician, a book about pregnancy; the der-

# Now, convenient B. I. D

in more effective broad-spectrum

# Clinically confirmed:

On a time-and-labor saving dosage schedule of 500 mg. (2 capsules) twice-a-day. Tetrex is a therapeutically effective and as free from adverse side effects as on 250 mg. (1 capsule) q.i.d.

Average adult dose: 1 Gm. per day in 2 doses of 500 mg. (2 capsules) each, or in 4 doses of 250 mg. (1 capsule) each.

Tet

TETRACYCU

-each capsule equivalent to 250

matologist, information on skin care of venereal disease; the psychiatrist, discussions of personality disorders.

# Where to Get Lists

You can take the first step by assaying the reading matter that applies to problems you handle frequently. Useful lists are available from the A.M.A. Bureau of Health Education; the Superintendent of Documents, U.S. Government Printing Office; the American Academy of Pediatrics and other medical associations; and the U.S. Department of

Health, Education, and Welfare, among many others.

A phone call to your local voluntary health associations will often bring well-planned material and reading lists on epilepsy, cerebral palsy, diabetes, mental health, or cancer. Or you can write to national headquarters of these organizations for latest literature and order forms.

# **Read Before Lending**

You alone can decide which of the available books are best for your patients. Before ordering a new book, you can often check

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rex CAPSULES

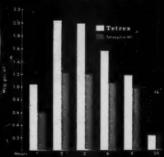
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¶It bolsters your authority. Patients who might discount your advice as just one doctor's opinion will take it seriously when you back it up with authoritative publications.

¶It helps put across the medical advice people need but won't ask for. A sullen boy who resists



". . . and then he charged me \$100 for removing the hemostat!"

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# PEACE OF MIND ATARAX

safety highlighted in every clinical report.

Depending on the condition treated, the effectiveness of ATARAX has ranged from 80 to 94%. But clinicians have agreed unanimously on its safety. After more than 85,000,000 doses - many on long-term administration at high dosage - no evidence of addiction, blood dyscrasias, parkinsonian effect, liver damage, depression or other serious side effects have been reported.

calms tense patients.

ATARAX produces its calming, peace-of-mind effect without disturbing mental alertness. In the tension/anxiety conditions for which it is intended, you will find ATARAX effective in about 9 of every 10 patients.

# prescribe ATARAX as follows:

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Supplied: Tablets, tiny 10 mg. (orange) and 25 mg. (green), bot-tles of 100. Syrup, 10 mg. per tsp., pint bottles.

Since response varies from patient to patient, dosage should be adjust-ed accordingly. Prescription only.



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## OFFICE LIBRARY

your oral suggestions may nevertheless accept the man-to-man loan of "How to Live with Parents," published by Science Research Associates. The American Cancer Society's pamphlet on self-examination of the breasts will help a nervous woman face her cancer fears.

¶It's a service that patients appreciate. It thaws out the doctorpatient relationship immediately. People accept the loan of reading matter as if it were a free consultation.

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Rapid, Prolonged Antacid Relief
... Balanced antacids — no laxation — no constipation

Proven Demulcent Action...Helps protect normal cells, encourages cellular repair

Anti-enzyme Action ... Necrotic pepsin and lysozyme action checked

## Composition:

Each 10 cc. of KOLANTYL Gel or each KOLANTYL tablet contains: Bentyl Hydrochloride.... 5 mg. Aluminum

### Dosage:

Gel — 2 to 4 teaspoonfuls every three hours, or as needed. Tablets—2 tablets (chewed for more rapid action) every three hours, or as needed.

### Supplied:

Gel — 12 oz. bottles. Tablets bottles of 100 and 1,000.

1. Johnston, R.L.: J. Indiana St. M.A. 46:869, 1953. 2. McHardy, G., and Browne, D.: Southern M.J. 45:1139, 1952.

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\*Merrell's distinctive antispasmodic that is more effective than aropine—free from side effects of atropine.2

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# = sound ulcer therapy

provides prolonged relief of ulcer pain.1

Kolantyl: 1. Neutralizes acid, 2. Inhibits pepsin, 3. Relieves hypermotility and spasm through musculotropic action, 4. Relieves spasm through neurotropic action, 5. Forms protecting demulcent, 6. Inhibits lysozyme.

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Thiamine	
Mononitrate B;)	10 mg
Ricoflavin (B.)	10 mg
Niacinamide	100 mg
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Vitamin B	4 meg n
Foric Acid	1.5 mg
Carolum Pantotherate	20 mg
Vitamin K (Menadione)	2 mg
Average Dose: 1-2 capsu	ies da ly.

# Ways to Preserve The Personal Touch

When you delegate work to your assistants, the patient still wants to feel that you're around. Here's how to personalize delegated work

By John E. Eichenlaub, M.D.

Last month in MEDICAL ECONOMICS you probably read "What Jobs Doctors Delegate—and to Whom." The article reported the tasks that a cross-section of doctors authorize their aides to do. But it omitted one thing that needs saying. I'd put it this way:

Sure, go ahead and delegate. It's good management to free yourself for important things by sloughing off the unimportant ones. But it's not good medicine if you thereby permit your practice to lose the personal touch that only you can give it.

Giving at least a few minor services yourself has this great value: It welds doctor-patient ties. No matter how routine the tasks, personal contact forms a bond between doctor and patient.

Harry Lewan's case brought that truth home to me. I'd never even prescribed for Harry myself. He had brought in a pollen extract that he'd been using success-



# pleasant tasting AGORAL for constipation

Whenever constipation complicates therapy, prescribe Agoral . . . for gentle effective laxation.

WARNED-CHILCOTT

## THE PERSONAL TOUCH

fully for several years and had asked me to give it to him. I saw him every week, but only for a moment while I jabbed the needle home.

Then one day he lingered after his shot. "Got a minute?" he asked.

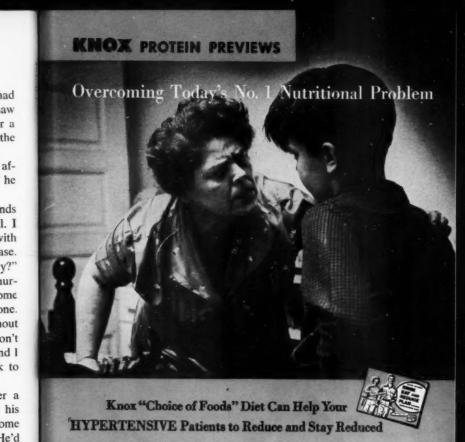
His eyes roved from my hands to the floor, then to the wall. I sat down, took a cigarette with him, and tried to put him at ease. "What can I do for you, Harry?"

"It's about my wife," he murmured. "When I came home from work yesterday, she'd gone. Just packed up and gone, without a note to me or anything. I don't know what to do, Doctor. And I don't know who else to talk to but you."

Harry calmed down after a while. And later he found his wife. But meanwhile he'd come to me to unburden himself. He'd used an emotional lifeline that had been formed in the course of a good deal of impersonal service by my assistant, made personal by me.

That's why I never allow any of my patients to escape *all* personal contact with me. If that were to happen, I'd probably lose much of my effectiveness as a healer.

A number of doctors have told me they always do some lesser



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3. Diets promote accurate adjustment of caloric levels to the special needs of the patient yet allow each individual

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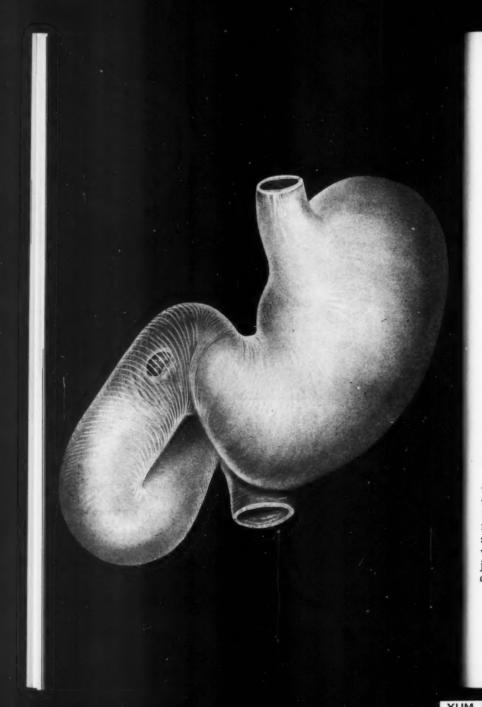
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# Pro-Banthine "proved almost invariably effective in the relief of ulcer pain,

in depressing gastric secretory volume and in inhibiting gastrointestinal motility."\*

"Our findings were documented by an intensive and personal observation of these patients over a 2-year period in private practice, and in two large hospital clinics with close supervision and satisfactory follow-up studies."\*

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Pro-Banthine Dosage

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G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

\*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 Cases, Am. J. M. Sc. 232:156 (Aug.) 1956.

## PRESERVE THE PERSONAL TOUCH

things themselves—things they could justifiably pass off to an assistant-just because they want patients to feel they've had their physician's personal attention.

These physicians, it seems to me, are on the right track. When I've asked them for hints on how to give every patient contact a touch of the doctor's own personality, they've offered the following suggestions:

1. Give the patient personal

attention at the crux of any visit. When a fellow comes to your office for a specific procedure, he usually expects you to perform that procedure yourself. You can, too-at least the key part of it.

One of my dermatologist friends carries this almost to an extreme. "I give my own I.V.s," he once told me. "I open the shutters on the UVR. I set up X-ray treatments personally, and I throw the switch." MORE



"He has your eyes."

"But you see sixty patients a day, don't you?" I asked.

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"That's right. I really see them. On every office call. That's an inflexible rule with me. I find it doesn't take any longer to shove home an I.V. when one of the girls has everything ready than it does just to look at the lesion and mutter a few pleasantries."

# That Pat on the Back

2. Give reassurance personally whenever it's required. Until the antibiotic era, some old-timers say, you could practice medicine with nothing but morphine, epsom salts, and a pat on the back. But the pat on the back was crucial. Doctors today still find it a major ingredient of successful care that just can't be delegated.

Mrs. Peterson taught me that. Her varicose ulcer had dragged on for months, and I had gradually sloughed her care off onto my office nurse. The nurse cooked up the Unna's paste. The nurse cut off the ragged boot Mrs. Peterson wore to the office and cleaned her leg. Then I dropped in, nodded my head, and ducked back out while the nurse put on another boot.

My office was becoming

cramped, so I had a thought: Why not shift patients like Mrs. Peterson off to the hours when I made hospital rounds? It seemed a fine idea, and we tried it. But as soon as the nurse started to put on the new boot, Mrs. Peterson said: "Isn't the doctor going to see me?"

"He's out of the office right now," my nurse replied.

"But how do we know it's doing all right?"

"It looks just fine, really it does."

"But the doctor hasn't seen it.
I'd better wait."

And wait she did, for two long hours. Finally, I came in and said her leg looked fine. That's all it took. She was satisfied, and the nurse went on. We never tried the totally absent treatment again.

How many patients come to your office for reassurance as much as for real care? I don't know. But when I try to think of a few persons I'm sure wouldn't act like Mrs. Peterson, I find myself running out of names. That's why I never fail to spend a few moments, at least, even with those whose major care has been shifted to an aide.

3. Don't delegate any service

that's even slightly painful. Patients usually take pain better if it occurs under the personal ministrations of the doctor. Perhaps they suffer less for the emotional support of his presence.

Once I watched one of the country's top orthopedists carefully supporting a patient's fractured leg while X-rays were being taken.

"Easy now," he said, as the attendants lifted the patient to the X-ray table. "All together—one, two, three . . . Now I'll hold the ankle while you take the A.P. . . . Got it? Fine. Now, Mr. Pear-

son, you'll have to roll up on your left side and throw your good leg over here. The boys will help you ... Ready? ..."

He probably spent more time there than it would have taken him to set the break. But I'm sure it was time well spent.

# 'Doctor's Orders'

4. Keep manifest control over every delegated task. As long as the patient knows you've expressly ordered each procedure, he's likely to view the aide who carries it out as an extension of your hands. [MORE]

In the anemia of pregnancy....

"The combined use of iron and cobalt [Roncovite] produces better clinical results, apparently by maintaining normal marrow function and by supplying adequate amounts of iron."\*

\*Holly, R.G.: Iron and Cobalt in Pregnancy, Obst. & Gynec. (Mar.) 1957.

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proved in clinical practice for dermatologic and ophthalmic infections

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Available sizes: Tubes of ½ oz. with applicator tip, ⅓ oz. with ophthalmic tip, and 1 oz.

# References:

- 1. McCarthy, John T., and Nelson, Carl T.: Pediatric Clinics of North America, Philadelphia, W. B. Saunders & Co., August 1956, p. 514.
- 2. Samuels, Saul S.: Angiology 7:532 (Dec.) 1956.
- 3. Panaccio, Victor: Canad. M. A. J. 75:592 (Oct.) 1956.



## PRESERVE THE PERSONAL TOUCH

That's why my partner uses routing sheets. "Take this back to the laboratory," he says to a patient. "The girl there will draw blood for some tests. She'll then show you to the lamp room, and Miss Jenkins will give you a treatment. After that, show this slip at the front desk, and Miss Coe will make another appointment for you."

I've known other doctors to use less complex methods. For instance, they merely give instructions within the patient's hearing. Or they send a note along to the aide. That sort of gesture—in the patient's mind—seems to convert office routine into personal service.

5. Even when tasks are delegated, take part in them in some trivial way. A minor adjustment or passing gesture is often enough to show the patient you're involved in his care. A few weeks ago, for instance, I was visiting an industrial surgeon when he suddenly got to his feet.

"Time for my rounds," he said, and motioned me to follow. We went down the corridor to the P.T. rooms, where several patients were ensconced.

# Revitalize the geriatric patient...

- stimulates cerebral circulation
- improves cerebral nutrition
- increases mental and physical vitality



86TH YEAR

"How's the back, Joe?" my friend said, pushing the head of the diathermy machine up a fraction of an inch.

"Fine. Doctor."

The surgeon moved on to the next bench. There he held his hand underneath an infra-red lamp, level with the patient's shoulder. "Isn't that a little warm, Bill?" he asked.

"Just a bit."

"Well, let's move it back an inch or two."

So it went, through several cubicles. When we got back to the consulting room, my friend said: "I've got a first-rate helper back there, you know. I don't have to check up. But I walk through every fifteen minutes, pushing this an inch one way, that an inch the other. By seeing every patient who's in for a treatment, I remind him that I've had something to do with his care."

6. Ask follow-up questions after the delegated work is done.
One way to show patients you're interested in their care even when you're not giving it personally is to ask them about it afterward.

The first time I did this, it was almost accidental. One of the in-

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## PRESERVE THE PERSONAL TOUCH

ternes had removed Mary Adams' sutures the day before. I simply dropped in to send her home.

"How's it going?" I asked.

"All right."

"Get your stitches out satisfactorily?"

"Well, they're out," she said curtly.

"What's the matter? Did it hurt?"

"It sure did!"

She then poured out a tale of woe that didn't end till I had personally dressed the wound and told her all was well. She felt better then. The interne had done a good job. But since the patient was a bit resentful, I was glad I'd raised the point. It's routine with me now to ask, about any delegated procedure, "How did it go?" Patients like the show of interest, and nurses and internes know why I ask the question.

Most of us delegate a good deal. If we didn't, we'd be swamped. But let's remember that a word along the way coming from the doctor may mean as much to the patient as a whole course of therapy coming from the doctor's nurse.



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Dosage: An initial dose of 5 to 10 mg. (1 to 2 cc.) should be injected *deeply* into the upper outer quadrant of the buttock. This may be repeated if necessary at intervals of 3 to 4 hours.

For further information, see S.K.F. literature.

Available: 2 cc. (10 mg.) ampuls in boxes of 6 and 100.

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Frequent nosebleeds, gum bleeding and easy bruising were observed in a high percentage of women who had repeated abortions, according to one study.1

Another investigator<sup>2</sup> reported abnormal capillary fragility in 80% of habitual aborters.

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C.V.P. provides the capillary-protectant factors of whole citrus bioflavonoid compound (sometimes referred to as "vitamin P complex"), combined with ascorbic acid. C.V.P. is water-soluble and believed to be more readily absorbed than relatively insoluble rutin.



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- 1. Science News Letter, March 1954
- 2. Greenblatt, R. B.: Obstet. & Gyn. 2:530, 1953

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(Arlington-Funk Laboratories, division) 250 East 43rd Street, New York 17, N.Y.

# Rx for a Freer Life: Get a Partner

[CONTINUED FROM 130]

his wife for another visit. Perhaps our wives had more foresight or more to gain; maybe my wife was a better salesman than I had been. Whatever the reason, within three months, Jim and I were a going partnership with as much income and as much free time as we wanted. More than that, we knew we were both practicing good medicine.

How did we go about establishing our partnership? What were the terms of our contract?

Adequate preparation was a prime factor in our success. The first thing we did was hold a conference. Each of us had his own lawyer. The four of us drew up a detailed agreement that even specified the location of our clinic, its name, the kind of medicine we would practice, and terms for severing the partnership.

The major provisions of the agreement went like this: I agreed to purchase Jim's equipment and supplies, which, of course, I turned over to the clinic for our common use. We both agreed to put up several hundred

dollars to buy more equipment. And I promised to lend the clinic an additional few hundred dollars so that we could have a drawing account from which to pay ourselves during the first few weeks of operation.

I turned over my records of former and current patients to the partnership. We agreed that all income from our medical services would be deposited in a joint bank account. We also agreed on a division of income—Jim to get 40 per cent the first year, 45 per cent the second, an equal share thereafter.

Our contract specified that we'd each get a full month's vacation each year, to be taken when mutually convenient. Each of us was also entitled to a month of non-cumulative sick leave.

Under a separate written agreement, I rented to the clinic my office, its furnishings, and the equipment I owned outright. The clinic reimbursed me by paying for the building's taxes and upkeep.

Once we signed the agreements, we forgot them. We had to get the partnership going.

We introduced a new bookkeeping system that enabled us (1) to give the patient a copy of



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## RX FOR A FREER LIFE

his bill at the end of his call (thus encouraging immediate payment) and (2) to retain two other copies for our permanent records. We also agreed to have a monthly audit.

We installed bigger and better equipment, too: a larger X-ray with more accessories, an improved microscope, an autoclave, and other new apparatus that enabled us to determine such things as hemoglobin, hematocrit, and blood count with greater ease. We even put in new examining tables, desks, filing cabinets, built-in shelves, and lights.

Naturally, we wanted our two aides to employ the new facilities to best advantage. So we had our auditor and the man who'd sold us the bookkeeping system train them in the use of the new business equipment. Jim and I, mean-



while, trained the girls in the appropriate clinical details of our work. Finally, we had a technician come in to teach them the technique of taking X-rays.

# It Proved Its Worth

The new equipment-together with the further training of our aides-soon proved its worth in smaller medical bills for our patients. Much less frequently did those who needed elaborate Xrays or laboratory tests have to be sent twenty miles to Waukegan. We could perform most such procedures right in our office, and at less cost.

We quickly decided to make all patients who came to us our patients rather than patients of one or the other. Of course, we tried to respect patients' personal preferences for a particular doctor. And except with OB casesabout which I'll say more laterwe were generally successful.

But from the first day we started working together, we discussed case after case with each other. Jim benefitted from my greater experience, I from his more recent education.

Soon after we began practicing, for example, he was unable to diagnose a certain skin dis-



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\*Ferguson, J. T., and Linn, F. V. Z.: Antibiotic Med. & Clin. Therapy 3:329, 1956.



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## RX FOR A FREER LIFE

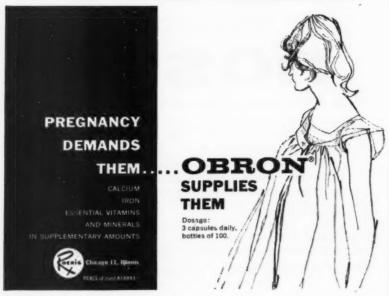
ease. Early in my medical career, I'd seen the condition often. So I recognized it right away.

To show the other side of the coin: I ran across an orthopedic disease that baffled me completely; in fact, I'd never even heard of it. But Jim recognized it as a disease he'd seen while in military service, and he was quickly able to confirm his diagnosis by X-ray. But for his knowledge, I might not have forced the patient to keep his weight off one leg, with the result that his recovery time might well have been prolonged.

Because of this easy consultation, I found it necessary to refer far fewer patients than I did when I was in solo practice. I was able, in particular, to handle a number of procedures that I had once turned over to an internist.

As you may have inferred, Jim and I worked well together. We differed in temperament and in many of our points of view. But we were always able to resolve our differences and pursue a common course of action.

This, in fact, leads me to emphasize that choosing the right partner is by all odds the most







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Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline hydrochloride and 250,000 units Mycostatin,

Minimum adult dosage: 1 capsule q.i.d. Bottles of 16 and 100.

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Sumycin Capsules (tetracycline phosphate complex equivalent to 250 mg. tetracycline hydrochloride): Bottles of 16 and 100.

Mysteclin Capsules (250 mg. tetracycline hydrochloride and 250,000 units Mycostatin): Bottles of 16 and 100.

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SQUIBB



Squibb Quality-the Priceless Ingredient

WHAT IS IT?

the phosphate complex
of tetracycline for initial
antibiotic blood levels...faster
and higher than ever before

+

antifungal activity of Mycostatin
for added protection against
monilial superinfection

therapy and antifungal prophylaxis



WHY SHOULD YOU PRESCRIBE IT?

Because it provides highly effective broad spectrum antibiotic therapy for many common infections and at the same time protects your patients against the monilial overgrowth so commonly observed during therapy with the usual broad spectrum antibiotics important part of setting up a partnership. I looked Jim over carefully before joining forces with him, as he did me. In three years of practice, I had no regrets. We'd made sure we agreed on the big things—what kind of medical care we wanted to provide, how much money we wanted to make, the free time we required.

# **Some Changed Doctors**

Patients were nearly as enthusiastic about the partnership as I was. To be sure, some of my oldest and most loyal switched to an older competitor of mine rather than risk being treated by a younger man who was unknown to them. And we learned by the grapevine that some potential patients didn't come to Jim because they wanted to avoid the possibility of meeting me: They owed me money, had had poor results at my hands, or had heard some of the gossip that went around during the period I was turning down so many cases.

Then, too, we told all our OB patients that we planned to alternate in seeing them during the prenatal period and that they'd be delivered by whichever one of us was available. Several moth-

ers-to-be accepted this provision reluctantly. One asked to be referred to an obstetrician. Another just didn't show up for further prenatal visits.

Fortunately, most mothers acknowledged the success of our obstetrical arrangement. One of them even likened it to the service rendered by her parents' old family doctor, who always left his patients confident that he was available in an emergency.

Our obstetrical practice—the yardstick of whether or not a rural doctor has a satisfactory patient load—increased by leaps and bounds. So did the number of our medical and surgical patients. In an unbelievably short time, our appointment schedules were full.

Despite the increase in total number of patients, my individual patient load was reduced by almost half. On a particularly heavy day in solo practice, I sometimes saw sixty different persons. In partnership, I rarely saw more than thirty-five—still more than I considered wise. Jim had a similar experience.

My personal net income went down, too—more than 25 per cent. Yet I still made a good living. And I felt I earned my monAnnouncing a unique new rauwolfia derivative . . .

# Harmonyl\*



advances in

psychopharmacology since the introduction of rauwolfia:

\*TRADEMARK

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# Harmonyl\*

A tranquilizing-antihypertensive agent which combines the potency of the rauwolfias with significantly fewer and milder side effects.

In MID-1955. Abbott Laboratories released for clinical trial a new alkaloid of Rauwolfia canescens. This new alkaloid, later named Harmonyl, received special attention because of the exceptionally low toxicity it exhibited in pharmacological testing.

Since that time, Harmonyl has been tried in conditions ranging from mild anxiety to major mental illnesses and in hypertension. Every characteristic of the drug was studied . . . evaluated. And from the reports, one fact stands out:

 In more than two years of clinical evaluation, Harmonyl has exhibited significantly fewer and milder side effects in comparative studies with reserpine. This, while demonstrating effectiveness comparable to the most potent forms of rauwolfia.

· Most significant: Harmonyl causes less mental and physical depression. And there are very few reports of the lethargy seen with many other rauwolfia preparations.

This is not to suggest, of course, that side effects will not occur with Harmonyl-as with any potent therapeutic agent. But the mildness of side effects, in the few instances in which they have been reported, suggests Harmonyl as a drug of choice in conditions ranging from mild anxiety to major mental illness and in hypertension.

#### Why fewer and less severe side effects?

Some investigators suggest that the evidence of less parasympathetic effect with Harmonyl in animals might also be true in man. In chronic toxicity studies with Harmonyl this was manifested by less diarrhea, "bloody tears" and ptosis in rats than was observed with the same dosage level of reserpine. Dogs also exhibited milder side effects. No organ toxicity or hematological change occurred over a wide dosage range.

#### Harmonyl as a tranquilizer

While Harmonyl's safety is most impressive, clinical investigators have reported other notable characteristics for this wide-range tranquilizer. For instance, following an eightmonth study of chronic, hospitalized mental patients, Ferguson' reported:

- Harmonyl benefited at least 15% more overactive patients than oral reserpine.
- Harmonyl was more potent in controlling aggression, requiring only one-half to two-thirds the dosage of reserpine.
- A number of patients experiencing side reactions during treatment with reserpine were completely relieved when changed to Harmonyl.

In his summary, Ferguson concluded: "The most notable impressions were the absence of side effects and relatively rapid onset of action with Harmonyl."

#### Harmonyl in hypertension

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Hypertension studies show that the average reduction in blood pressure obtained with Harmonyl compares closely to that obtained with reserpine. The tranquilizing effect of the two drugs also appeared similar, except that few cases of vertigo, sense of detached existence or disturbed sleep were seen with Harmonyl.

Dosages In mild anxiety, as little as 0.1 mg. of Harmonyl a day may be effective. In institutionalized psychiatric patients, not less than 2 to 3 mg. a day is likely to be beneficial.

In mild essential hypertension, treatment may be started with one 0.25-mg. Harmonyl tablet three or four times a day. After about ten days (or sooner, depending upon response), dosage may be reduced. A maintenance dose of 0.25 mg. daily is often sufficient.

Precautions, Contraindications As with other forms of rauwolfia, Harmonyl must be used cautiously in peptic ulcer and epilepsy and in patients about to undergo surgery or electroshock treatment. Despite the infrequency of reports involving depression, patients with a history of depressive episodes should be watched carefully.

Professional literature is available upon request.

Supplied: Harmonyl is supplied in 0.1-mg., 0.25-mg, and 1-mg. tablets.

Reference: Ferguson, J. T.: Comparison of Reserpine and Harmonyl ip Psychiatric Patients: A Preliminary Report, Journal Lancet, 76:389, December, 1956.

#### RX FOR A FREER LIFE

ey an easier way: My income per hour went up by at least one quarter, possibly because I spent only about half the time I formerly did in travel.

The increase in free time was, of course, my greatest benefit from the partnership. Here's how we obtained such time: I was off after office hours and home visits on Tuesday afternoon as well as all day Wednesday. Jim was free after Monday afternoon's duties and again all day Thursday. Week-ends we alternated: The man off duty answered the telephone from Friday afternoon un-

til Saturday morning; then the one who had the duty took over Saturday and Sunday. As much as we could, we alternated hospital visits. But we both went for surgery and often for obstetrical work, too.

Other physicians in Antioch foisted a good deal of their night work onto us. But during the time we were not supposed to work, we could count on uninterrupted rest or relaxation. For the first time in our marriage, my wife and I could entertain or go out without fear that we'd be interrupted.

[MORE]





 Controlled disintegration capsules of 30 mg. pentaerythritol tetranitrate (PETN). Also available, Pentritol-B Tempules with 50 mg. butabarbital added. One PENTRITOL Tempule every 12 hours assures 24-hour protection from anginal attack in almost all patients. A 10 mg release of PETN every four hours maintains continuous coronary vasodilation, eliminating all dangerous medication gaps. Only PENTRITOL Tempules offer the protection of 24-hour uninterrupted prophylaxis.

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Mead Johnson phosphorus-free prenatal vitamin-mineral capsules

contain calcium, no phosphorus



Just 1 to 3, small, easy-to-swallow capsules daily—according to her individual need—provide generous amounts of iron, calcium and vitamins that help her to meet the stress of pregnancy. And they're economical, too—in bottles of 100.

For some patients, you may prefer to prescribe Natalins, which contain both calcium and phosphorus.

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#### RX FOR A FREER LIFE

The free time was doubly enjoyable because of the confidence I had in my partner: I hardly thought of my practice when I wasn't working. It was a big change from my days in solo practice. Best of all, I could sleep nights with the knowledge that I was doing a good job-as a physician, husband, father, and citizen.

If I'm favorably disposed toward partnership practice, then, it's perhaps understandable. To me, it meant not only more free -and carefree—time, but also better medical facilities, easy consultation, continuous cover of my practice, and disability protection in case I fell ill. To my patients, these advantages spelled better medical care. END

### **Current Practice**

The chief of our hospital's neurosurgical service was both skillful and irascible. While operating, when he wished to seal off a blood vessel, he'd place his hemostat on the vessel and then say gruffly to his assisting interne, "Touch me." Whereupon the interne would apply the electro-cautery, with its coagulating current, to the shank of the chief's hemostat.

One day a new interne was on the service. This man was primarily interested in psychiatry, and somehow had missed the briefing that the resident in neurosurgery usually gave new internes. In the tension-filled operating room, the new man was assisting the chief on a particularly complex case.

Came a point when the surgeon used his hemostat. "Touch me," he barked.

Above his mask, the wide-eyed interne blinked. But his hesitation was brief. Swiftly and precisely, with the disciplined response of the true man in white, he applied the electro-cautery to the surgeon's rubber-gloved wrist, burning a half-inch hole through the glove and the gown beneath, and toasting the surgeon's skin.

The surgeon still burns when he thinks of it.

-SEYMOUR E. WHEELOCK, M.D.

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NEW

# PACA

#### TO "NORMALIZE" THE THINKING PROCESSES\*

AN ADVANCE: A superior, new phrenotropic agent, Pacatal represents an important advance in the treatment of mental and emotional disorders. This new phenothiazine derivative has a tranquilizing action, but overcomes many of the disadvantages inherent in treatment with the earlier phenothiazine compounds.

TRANQUIL, YET RESPONSIVE: With Pacatal, the physician now has an agent which exerts a calming influence, but does not "flatten" the patient. Following treatment with Pacatal, patients are calmed, yet they remain alert, active and cooperative.

FEWER SIDE EFFECTS: Pacatal also has fewer side effects at recommended dosage levels. Atropine-like effects may occur in some patients, but tend to disappear with continued therapy. Occasional troublesome cases are usually controlled with oral doses of neostigmine.

DOSAGE: Usual dosage for the ambulant patient is 25 mg. 3 or 4 times daily; for the hospitalized patient, 50 mg. 3 or 4 times daily. Complete literature and dosage instructions (available on request) should be consulted.

SUPPLIED: 25 and 50 mg. tablets in bottles of 100 and 500. Also available in 2 cc. ampuls (25 mg./cc.) for parenteral use.

\*Many Investigators report that Pacatal seems to have a "normalizing" action, i.e., patients appear to think and respond emotionally in a more normal manner.

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BRAND OF MEPAZINE

# What Some M.D.s Think of Closed Panels

[CONTINUED FROM 194]

objections—e.g., the alleged poor quality and poor pay of panel medicine.

"I must be able to select the specialists I refer patients to," says a 32-year-old pediatrician. "These panels have doctors of very uneven abilities. I trained at Cornell, Columbia, and McGill, and I'm horrified at the children's surgery performed by some panels."

Or listen to this story from a young internist: "About a year ago a H.I.P. group offered me 70 cents per patient per month and -for \$5,000-a partnership. I refused because I feel that in a closed panel the patient is abused and the doctor is a slave laborer. For 70 cents per patient, some H.I.P. groups want the doctor to take care of hospital patients as well as office calls. The system makes the doctor or layman who heads the organization a rich man. But it cuts the practicing physician down to very small size." MORE

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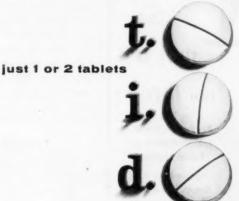
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Effectiveness and safety confirmed by five years' experience in millions of patients

Convenient t.i.d. dosage—may be given without regard to meals

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#### CLOSED PANELS

In the same vein, a 64-yearold gynecologist reports that one panel recently offered him \$50 a case to handle 200 to 300 OB cases annually. "Unless I turned the work over to an interne," he comments, "I'd probably have a coronary trying to deliver 300

babies a year!"

The reason why some G.P.s are especially opposed to the panels is that they fear being used merely as traffic cops. Says a former president of the Brooklyn Academy of General Practice: "The closed-panel G.P. is nothing but a referral service. He earns his fees by not treating patients. He simply sends them on to the specialists."

#### Unethica! Ads?

This doctor adds that he's repelled by what he considers the panels' unethical advertising. "Let's assume a new housing project opens across from my office," he says. "Suppose I then permit a friendly tradesman to pass my card out wholesale to the occupants. Everybody knows what would happen: I'd be brought up on charges. I might even lose my license.

"But suppose a group of doctors hires somebody to go into that same housing project to tell the tenants to drop whatever doc-

# "All I want to do is just sit."

"I always feel down in the dumps, Doctor. Why, I can't even eat."

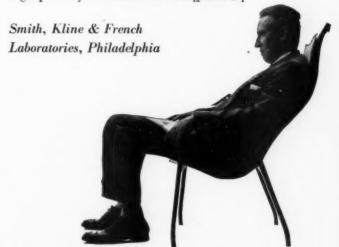
"Trophite', a high potency vitamin B<sub>12</sub>-B<sub>1</sub> formula, has been found to be highly effective in patients who describe their vague symptoms in such increasingly familiar terms as: "I'm all worn out"; or, "I don't feel like doing anything—it's even an effort to eat."

The high dosage combination of B<sub>12</sub> and B<sub>1</sub> apparently helps the "run-down" patient in two ways: (1) Because B<sub>12</sub> and B<sub>1</sub> stimulate appetite, 'Trophite' increases food intake. (2) It promotes proper utilization of food.

Each delicious teaspoonful (5 cc.), or convenient tablet, supplies 25 mcg. B<sub>12</sub>, 10 mg. B<sub>1</sub>.

# Trophite\* for appetite

high potency combination of B<sub>12</sub> and B<sub>1</sub>



\*T.M. Reg. U. S. Pat. Of.

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#### WHAT SOME M.D.S THINK OF CLOSED PANELS

tor they're using and to sign up with the panel instead. Is that legal? It is. There's a special law. But is it ethical? It is *not!*"

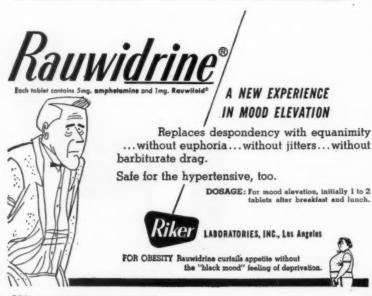
One more common reason for refusal: Many doctors believe they'd lose prestige if they joined a plan. "Closed panels are looked on with active disfavor by most doctors in my community," says a 36-year-old general surgeon. "So they're not for me."

"After all, who are the doctors in those plans?" asks the president of one of New York City's five medical societies. "Why should we kid ourselves? They're men who haven't been successful elsewhere."

(Replies Dr. George Baehr, president and medical director of H.I.P.: "Fifty-one per cent of all H.I.P. physicians, including family doctors, are diplomates of the American boards, compared with 34 per cent of New York City physicians generally.")

#### And the Rest ...

As I've said, the survey indicates that fully two-thirds of the city's physicians have had very



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o 2 ch.

# The growing use of Serpasil\*

Treasprine CIBA

# in everyday practice

One of the safest, least toxic and most effective therapeutic agents for many conditions in which the weaker tranquilizers or sedatives are inadequate.

On the following pages you will find information on these aspects of Serpasil therapy:

#### PAGE

- 2 emotional disorders
- 3 hypertension
- 4 tachycardia
- 4 alcoholism
- 5 acute hypertensive crises
- 5 acute psychotic disturbances
- 6 side effects and precautions

# in emotional disorders



## Serpasil® provides true emotional control

In your daily practice there are undoubtedly many patients whose degree and type of emotional disturbance—characterized by overexcitation, anxiety and agitation—can not be adequately controlled with sedatives or weaker tranquilizers. These are the patients whom you can help most with once-a-day administration of Serpasil. For Serpasil actually sets up a "stress barrier" against anxiety and tension the patient would otherwise find intolerable. With Serpasil you can control the emotional turmoil of disturbed individuals; and because Serpasil is restricted to prescription use, control remains in your hands.

Although it is a first choice in hypertension, Serpasil does not significantly lower blood pressure in normotensive patients.

USUAL DOSE: Initial range is 0.1 mg. to 0.5 mg. (two 0.25-mg. tablets) daily. As little as 0.1 mg. is sufficient for maintenance in some patients. Serpasil can be given in a single daily dose.

"...relieves anxiety and irritability and calms the patient so effectively that because of this latter property alone, the drug should remain in the medicinal armamentarium."

# in hypertension



### Serpasil® can always be considered first

- BECAUSE alone: Serpasil successfully reduces blood pressure, slowly and safely, in about 70 per cent of cases of mild to moderate hypertension.
- BECAUSE as a "primer": Serpasil may be advantageously used to begin antihypertensive therapy, however severe the case, since it gently adjusts the patient to the physiologic setting of lower pressure.
- BECAUSE as a "background" agent throughout other therapy: Serpasil permits lower dosage of the more potent antihypertensives needed for refractory cases, thus minimizing the incidence and severity of side effects.

USUAL DOSE: Initially, two 0.25-mg. tablets. After a week, daily dose should be reduced to 0.25 mg. or less for maintenance.

"...a useful agent for the treatment of certain types of hypertension...The action...was increased by combining it with [Apresoline]..."

<sup>1.</sup> Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955.

<sup>2.</sup> Winsor, T.: Ann. New York Acad. Sc. 59:61 (April 30) 1954.

# in tachycardia



## Serpasil® slows the rapid heart

Many patients can benefit from the heart-slowing action of Serpasil. Those in whom tachycardia is deleterious are helped by its unique bradycardic effect, for Serpasil prolongs diastole and allows more time for the myocardium to rest. Blood flow and cardiac efficiency are thus enhanced.

USUAL DOSE:  $0.1\ mg.$  to  $0.5\ mg.$  (two 0.25-mg. tablets) daily. After one or two weeks dose may be reduced.

"Reserpine [Serpasil] was found useful in relieving the tachycardia and emotional symptoms associated with cardiac arrhythmias, thyrotoxicosis, neurocirculatory asthenia, and even coronary heart disease."

Halprin, H.: J. M. Soc. New Jersey 52:616 (Dec.) 1955.

# in alcoholism



### Serpasil relieves drink-inducing tension

As a part of long-term therapy, oral Serpasil helps the alcoholic "stay on the wagon" by relieving drink-inducing tension, making him more amenable to your counseling.

In acute alcoholism, delirium tremens can generally be controlled within 24 hours with parenteral Serpasil... without the addicting or soporific dangers of drugs such as paraldehyde.

USUAL DOSAGE: Chronic phase: two 0.25-mg. tablets or less daily. Acute phase: two 2.5-mg. parenteral doses (1 ml. each) 3 or more hours apart. Occasionally, repeat injections of 2.5 mg. every 4 to 6 hours may be necessary.

"...the tranquilizing and anxiety-relieving properties of this drug [Serpasil] offer the possibilities of its being extremely helpful for the long-term therapy of the chronic alcoholic."

# in acute hypertensive crises



### Parenteral Serpasil®

Serpasil can be used alone in hypertensive emergencies or as a background to more potent antihypertensive agents. Its antihypertensive action is prompt and well-tolerated.

USUAL DOSE: 2.5 mg. (1 ml.) intramuscularly. Additional intramuscular doses of 2.5 mg. may be given as necessary every 8 to 24 hours.

"...appears to be [a] treatment of choice for hypertensive crises."

Griffin, R. W., Stover, J. W., and Ford, R. V.: New England J. Med. 254:593 (March 29) 1956.

# in acute psychotic disturbances



### Parenteral Serpasil

The family physician is often called to subdue and arrange for quick hospitalization of patients who suddenly experience violent psychotic episodes. With intramuscular Serpasil these patients are quickly tranquilized and rendered amenable to 'quiet' hospitalization.

USUAL DOSE: 5 mg. intramuscularly followed, if necessary, by another 5-mg. intramuscular dose in 90 minutes.

"It is now possible to discreetly manage acutely disturbed psychiatric patients by the prompt administration of adequate doses of reservine (Serpasil)."

Ayd, F. J., Jr.: The Pharmacologic Management of Everyday Psychiatric Problems (A Scientific Exhibit). Presented at the Clinical Meeting of the American Medical Association, Boston, Mass., Nov. 29 - Dec. 2, 1955.

# Serpasil:

The side effects of Serpasil are characteristic of all rauwolfia preparations.

Although millions of patients have taken Serpasil over the past several years, very few serious side reactions have been reported. There have been no cases of blood dyscrasia, liver damage, addiction or withdrawal symptoms. When patients are properly selected and the lowest effective maintenance dose is established, the physician can prescribe Serpasil confidently, with little fear of untoward reactions.

DEPRESSION Mental depression, which has developed in a small percentage of patients treated with rauwolfia, should be differentiated from the transient change in mood or physical fatigue that is experienced by almost everyone in the general population. It should also be distinguished from the lethargy experienced by some patients on rauwolfia therapy.

In the few cases in which mental depression does occur, there is some question as to whether or not it is a direct effect of rauwolfia. According to Mayo Clinic investigators,1 the evidence indicates that rauwolfia per se does not cause depression, but rather that it unmasks an underlying susceptibility to depressive reactions, Kinross-Wright2 states: "It is likely that depression will occur only in a predisposed individual or in one who is already mildly depressed." Ayd; in a (very) recent paper, states: "That this drug may cause depression is uncertain. After reviewing a large number of so-called drug-induced depressions it appears that in some cases what was called depression was excessive tranquilization, while in the rest, the patients were depressed before the drug was started, and what the drug did was make the depression more apparent."

Whether or not it is an effect of rauwolfa, physicians and responsible members of the patient's family should be on the alert for the development of side effects and precautions

symptoms of depression, particularly in patients with a history of pre-existing depressive tendencies. Daily doses above 0.25 mg. are contraindicated in the latter group. On withdrawal of rauwolfia, depression usually disappears, but active treatment, including hospitalization for shock therapy, has been required in some cases.

Adjunctive use of mood-elevating agents such as Ritalin is often sufficient to reverse mild depressions or drug-induced lethargy.

OTHER SIDE EFFECTS In addition to lassitude or drowsiness, other mild side effects of Serpasil include occasional nasal stuffiness and increased frequency of defecation and/or looseness of stools. Rarely, anorexia, headache, bizarre dreams, nausea and dizziness occur. With parenteral Serpasil there is a possibility of marked hypotensive effect; therefore, the blood pressure should be taken before injection and the patient kept under observation for 5 or 6 hours thereafter. Because initial doses above 0.3 mg. tend to increase gastric secretion of hydrochloric acid, daily doses above 0.25 mg. are contraindicated in patients with a history of peptic ulcer and lower doses should be used with caution.

For further details on side effects and precautions, write Medical Service Division.

1. Litin, E. M., Faucett, F. L., and Achor, R. W. P.: Proc. Staff Meet., Mayo Clin. 31:233 (April 18) 1956. 2. Kinross-Wright, V.: Wisconsin M.J. 55:1073 (Oct.) 1956. 3. Ayd, F. J., Jr.: Presented at the Sesquicentennial Convention of The Medical Society of The State of New York, New York City, Feb. 18, 1957.

SUPPLIED: TABLETS, 0.1 mg., 0.25 mg., 1 mg., 2 mg. and 4 mg. ELIXIRS, 0.2 mg. and 1 mg. per 4-ml. teaspoon. PARENTERAL SOLUTION: Ampuls, 2 ml., 2.5 mg. Serpasil per ml.; Multiple-dose Vials, 10 ml., 2.5 mg. Serpasil per ml.

APRESOLINE® hydrochloride (hydralazine hydrochloride CIBA)

RITALIN® hydrochloride (methylphenidate hydrochloride







An evaporated milk formula costs half as much as a proprietary formula and it supplies additional benefits. The considerable savings, over the formula period, can be important to many young parents.

The physician specifying an evaporated milk formula does so because of its nutritional adjustability for the individual infant compared to the inflexible proprietary formula, not on

a cost basis. Economy is purely a secondary benefit.

Young parents appreciate the doctor's counsel even more when they learn that the evaporated milk formula he prescribes as best for baby, brings worthwhile savings as well.



Optimum prescriptionquality in today's trend to the individualized formula.



#### CLOSED PANELS

limited-or no-dealings with any closed panel. About a fourth of these men say they've no opinion one way or another. About an eighth think closed-panel medicine a good thing. The remaining five-eighths are against it in principle.

#### 'Army Medicine'

"It's not good for either doctor or patient," says a 46-yearold ophthalmologist. "I call closed-panel practice 'Army medicine'."

"When the panel patient gets into real trouble," says a 50-yearold internist, "he comes back to Papa."

Yet some doctors who disapprove panel practice for themselves concede that it may be all right for other physicians. "Personally, I'm against it," says a 67-year-old G.P. "For many doctors, though, it means getting a fifty-fifty chance of maintaining a decent standard of living. And so, even with its obvious professional stigma, it's something to be tolerated until something better comes along."

### **Easy Way Out?**

"I don't want it for myself," comments a 56-year-old general surgeon. "But if I were starting in practice today, what with the



Parenzyme has been used successfully as an adjunct in severe pulmonary diseases (including bronchial asthma, emphysema, bronchiectasis) to loosen inspissated mucus plugs even when other recognized therapy has failed.1,2 "The uniformity of response of these patients [25] was striking."2 X-rays of

asthmatics show "dramatic improvement" in densities and truncal markings and confirm subjective findings of relief.2 Copious expectoration within 1-3 days of treatment was followed by decrease of dyspnea.2 For relapses, repeated courses of Parenzyme were as effective as the first one.2

# New Parenzyme Aqueous

provides the proven therapeutic efficacy of Parenzyme in a new aqueous menstruum. Parenzyme Aqueous offers these advantages:

- · minimal pain on injection
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Dosage: Inject intragluteally 1 ml. (5 mg.) daily for first week; 2 to 3 times weekly for 2nd and 3rd weeks; 1 time weekly for 4th week. Then alternate 2 weeks' rest periods with repeated 4 weeks' courses as needed.

Supplied: New Parenzyme AQUEOUS and Parenzyme in oil in multiple-dose vials.

References: 1. Golden, H. T.: Delaware M.J. 26:267, 1954. 2. Silbert, N. E.: Dis. Chest 29:520, 1956.

Products of Original Research

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THE NATIONAL DRUG COMPANY Philadelphia 44, Pa.

MEDICAL ECONOMICS · MAY 1957 301

#### WHAT SOME M.D.S THINK OF CLOSED PANELS

tax situation and all, I might consider it an easy way out."

A 37-year-old obstetrician sums it up this way: "I'm against closed-panel medicine in principle. But I gather there's a definite trend toward it. So despite my objections, there may come a day when I'll accept it."

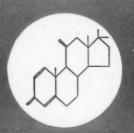
#### The Main Conclusion

From the above comments and from hundreds like them one main conclusion can legitimately be drawn:

Rightly or wrongly, the individual doctor in the admittedly atypical City of New York seems far less exercised over closed panels than are the spokesmen for organized medicine. The survey indicates that such heated opposition as there is in the city comes very seldom from the medical men who've had some personal experience with panel practice.

Thus the question arises: Is the threat really as menacing as some medical leaders believe it to be? If so, an educational campaign within the ranks of the medical profession would seem to be in order.

ROUTINE ADJUNCT TO STEROID THERAPY'



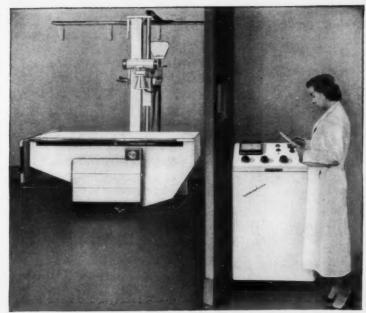
# **AMPHOJEL**

double gel for biphasic action

combats corticosteroid-induced gastric distress

1: Bollet, A.J., Black, R., and Bunim, J.J.: J.A.M.A. 158:459 (June 11) 1955





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# How Do Good Doctors Get That Way?

[CONTINUED FROM 173]

how carefully they examined a patient's ear, elbow, or epidermis—and on whether such examination seemed indicated by the patient's complaint. (As it turned out, the North Carolina doctors who examined individual organs or regions most thoroughly were also likely to do the greatest number of complete physical examinations.

The research check-list included twenty-odd examiningroom procedures. A doctor's handling of each procedure was given one of two or three possible point values, thus:

#### Examination of Chest By Percussion

	Point Value
Not done	0
Chest thumped perfunctorily	1
Percussion over all major	
lobes, determination of di	a-
phragmatic level, diaphra	g-
matic movements	2

Similar point values were given to examinations of the eyes, ears, nose, mouth, neck, lymph nodes, heart, etc. Only 2 per cent of the G.P.s got top scores for



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Point Value

..0

..1

a-

g-

...2

yes, nph cent for

## PRODUCT and PEDIGREE

It isn't conspicuous, but you have often seen it—the number on the label of every original pharmaceutical package. It may have one digit, or it may contain seven or eight. But the size of the number is of no consequence. It has meaning only because of the story it tells. For this is the control number placed there by the manufacturer—his key to the life history of the drug on which it is stamped, and your certificate of accuracy as you prescribe the drug for your patients.

The control number is the manufacturer's record of exactly what materials went into the product and from where they came; when the product was made and by whom; when it was analyzed; and to whom it was sold. In short, the number identifies the product's pedigree.

And this identification is only one phase of the elaborate and painstaking measures taken by the pharmaceutical industry to avoid mix-ups and accidental contaminations,



and to provide your patients with medicinals of uniform strength and accuracy.

This is quality control.

Quality can be defined as "character with respect to excellence". In pharmaceuticals, excellence is a composite of many elements. And it is excellence which demands exactness, to the full extent to which man can test and weigh and measure.

Two qualities will instantly occur to you as essential purity of materials, and accuracy of dosage. And certainly purity of both the active ingredients and the excipients, and accuracy of the quantities dispensed, are vital.

But other elements are vital, too:

Stability, for example, as it refers to the maintenance of stated potency; disintegration time of compressed tablets and dissolution time of coated tablets; sterility of injectables and ophthalmic preparations; viscosity and surface tension of liquids; melting point; and uniformity of taste, smell, appearance and texture.

In pharmaceutical manufacture, this quality control is carried out conscientiously by well-trained men.

Think of the problems involved in the measurement of small quantities. The next time you prescribe 50 micrograms of vitamin B<sub>10</sub>, remember that a drop of water

weighing 50 milligrams is heavier by a thousand times. The job of the control chemist is to make sure that your patient actually gets 50 micrograms—not 25 or 100.

The analytical side of control work is also exacting, for it involves quantitative and qualitative analysis of complex chemical mixtures. A multiple vitamin formula containing ten ingredients is an example. It is not a simple matter to mix the ten vitamins together. But when they are mixed, ingenious analytical methods are required to determine from the finished product that all ten ingredients are present in their correct amounts and that an eleventh has not slipped in unnoticed or by substitution.

\* \* \*

Of course, some elements of quality control in pharmaceuticals are comparable to control procedures in other industries. The weight of active ingredients is maintained within limits just as the manufacturer of razor blades controls the sharpness of his edges within reasonable tolerances. But with most standards in pharmaceutical production there can be no compromise with absolutes.

. . .

When a laboratory develops a new drug, it must devise scientifically accurate methods for identifying and testing it separately as well as in mixtures. And these methods must be defined when the company files a new drug application with the Food and Drug Administration.

In the ceaseless search for faster, more accurate mean, of quality control, new techniques and instruments are being constantly devised. Fluorophotometers, spectrophotometers, automatic titrimeters—these are among the newer laboratory tools. Polarizing microscopes equipped to measure optical constants indicate melting points. Paper chromatography and gas chromatography have their uses. Radioactive isotopes help assay preparations containing rauwolfia compounds, for example. Bacterial cultures assist in measuring the activity of antibiotics as well as the potency of vitamins. And so it goes.

According to the U. S. Public Health Service, these tireless, painstaking, comprehensive quality safeguards and testing procedures account for from 10 to 15 per cent of the production costs of pharmaceutical companies. Yet, like the air we breathe, quality control is apparent only if it is lacking.

It may be good for the soul to remind ourselves once in a while how easy it is to take the indispensable for granted.



THE HEALTH NEWS INSTITUTE

60 East 42nd Street, New York 17, N.Y.





their eye examinations (which were supposed, ideally, to include conjunctivae, visual fields, pupillary reactions, and extraocular movements). But, at the other extreme, 62 per cent got top scores for their mouth examinations (including tonsils, throat, teeth, gums, and tongue).

In the researchers' opinion, 45 per cent of the doctors didn't have their patients take off enough clothes to allow easy access to the parts being examined. Some of them tried to perform auscultation of the heart or lungs through several layers of clothing. Others might drop the stethoscope chest piece down through the neck of the patient's blouse. A number of men did abdominal examinations with the fully dressed patient sitting or standing.

Though the state had a mild polio epidemic at the time of the study, 71 per cent of the doctors did no neurological examinations. Another 20 per cent tested only knee and ankle jerks. No more than 9 per cent "tested the reflexes in all extremities and made other neurological tests where indicated." [MORE]

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COMPOSITION: Magnesium Trisilicate, Calcium Carbonate, Magnesium Hydroxide, Peppermint.



WHITEHALL PHARMACAL COMPANY - NEW YORK, N. Y.

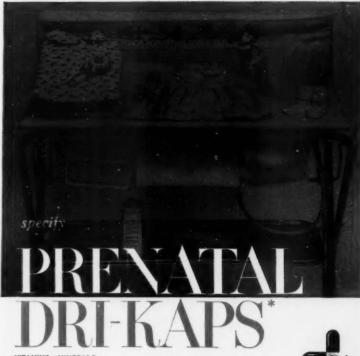
#### GOOD DOCTORS

Many of the men apparently figured that he who pays Dr. Piper should call the tune: Eighty-three per cent of them omitted an indicated rectal exam, 64 per cent a vaginal exam, because of the patient's "implied or expressed disapproval." It was so unusual for any man to use a proctoscope that the six G.P.s who did so were given extra credit. Only one of the G.P.s routinely examined the breasts of female patients during general check-ups.

While their vaginal specula gathered dust, the doctors seemed determined to wear out their sphygmomanometers. "Measurement of the blood pressure is probably the most frequently executed and least understood examination in general practice," says the report.

Every one of the G.P.s took routine blood pressure readings, probably because he thought patients expected him to. But only





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#### to meet additional dietary requirements throughout pregnancy and lactation

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Ferrous Sulfate Exsiccated .... 20 mg. Manganese (in MnSO<sub>4</sub>) . . . . . 0.12 mg.

#### HOW DO GOOD DOCTORS GET THAT WAY?

17 per cent of the men took careful systolic and diastolic measurements and examined the peripheral pulses when indicated.

#### **Laboratory Tests**

Here, it may not be too easy for you to compare your performance with that of the typical North Carolina G.P.: The touchstone was whether the doctor chose a laboratory procedure that—in the *observer's* opinion—seemed to fit the complaint. But you may still want to consider whether you routinely omit or include certain tests through

force of habit rather than because of clinical indications.

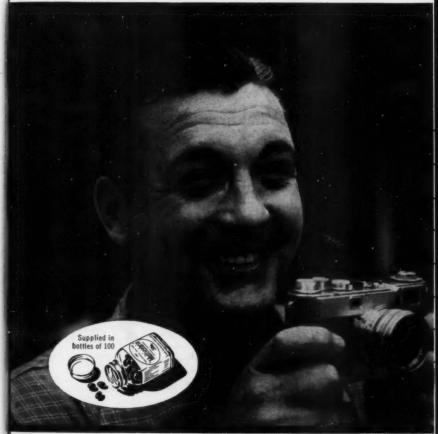
The research check-list of laboratory tests comprised seventeen entries, ranging from urinalysis to blood chemistry and bacteriological tests. The tests most consistently ordered were urinalyses (used by 89 per cent of the G.P.s when they seemed indicated), examinations of cerebrospinal fluid (85 per cent), and diagnostic X-rays (82 per cent). Only about half the men called for red or white blood cell counts, biopsies or smears for cancer, and ECGs or BMRs. [MORE]



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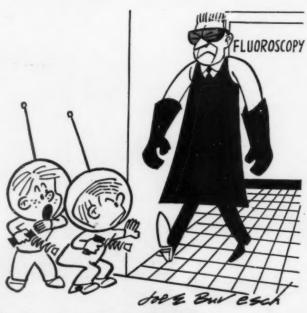
#### HOW DO GOOD DOCTORS GET THAT WAY?

Forty-three per cent of the doctors were judged to be careless about sterile technique. They used unsterilized syringes, forgot to wipe the patient's skin before a shot, and forgot to wash their own hands after contamination.

#### Therapeutic Measures

The observers didn't attempt to judge the G.P.'s treatment of every sort of case. Instead, they concentrated on his handling of potentially dangerous drugs and on six complaints that, in their view, come up frequently in general practice, are fairly easy to diagnose, and call for a wide but representative range of therapeutic measures. If some of these complaints don't fall within the scope of your own practice, perhaps you can use comparable examples.

[MORE]



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Gantrimycin is effective against many infections refractory to other antibiotics because Gantrisin interferes with the basic nutrition of the pathogens, and oleandomycin attacks another vital system in the growth and reproduction of the pathogens.

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That knowledge will come when the riddle of cancer is solved in the research laboratories. To support this vital work, and to carry on its education and service programs, the American Cancer Society seeks \$30,000,000 this Spring. We are again appealing to the public to "fight cancer with a checkup and a check."

The check is insurance for tomorrow. The insurance for today is largely in your hands, doctor. Fighting cancer with a checkup is our *immediate* hope for saving lives.

AMERICAN CANCER SOCIETY



#### HOW DO GOOD DOCTORS GET THAT WAY?

Among the thought-provoking findings in the seven surveyed categories:

Sixty-seven per cent of the men received low ratings because they routinely gave antibiotics for all *upper respiratory infections*. They reportedly made no attempt to find out whether such infections were viral or bacterial in origin. Many of them thought penicillin was good for the common cold, while others argued that it was harmless or might prevent complications.

¶ Eighty-five per cent prescribed "shot-gun" preparations of vitamins, minerals, iron, etc. for *anemia* without trying to track down its cause.

¶ Fifty-seven per cent prescribed some drug or other for hypertension without probing into its possible causes. They didn't advise the patient to take off weight, throw away his saltcellar, get more rest, etc.

¶Eighty-three per cent seemed either indifferent or uneasy when faced with psychological problems. They often spoke of "malingering," "hypochondriacs," "problem patients," or of "getting them out of the office

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#### HOW DO GOOD DOCTORS GET THAT WAY?

quickly." Some of the men made half-hearted attempts to treat disturbed patients with vitamins, antacids, iron preparations, sex hormones, or antispasmodics. And a few of them set aside special times when such patients could talk out their troubles. But the doctor's willingness to listen wasn't always evident.

¶ Only one-third of the G.P.s apparently recognized obesity as a clinical problem with psychological overtones. These men gave their overweight patients detailed diet lists, explained the rationale of weight reduction, and provided "needed emotional support." The other G.P.s completely ignored the problem unless the patient himself mentioned it. Then these doctors were likely to prescribe an appetite depressant, along with some general advice about cutting down on starches and fat.

¶ Perhaps because they were rarely called on to treat congestive heart failure, few of the G.P.s reportedly handled the condition with skill. The report says only one out of four "individualized the dosage of drugs," recommended low salt diets, and "utilized the patient's weight, determination of circulation time.

and respiratory vital capacity as aids to diagnosis and management."

¶When prescribing potentially dangerous drugs, only about half the doctors kept an eye out for possible complications-by asking about previous reactions to penicillin shots, for instance, or by giving "proper supervision and advice" to patients who were taking propylthiouracil, ACTH, cortisone, and other such drugs.

#### Preventive Medicine

Are you educating your patients to the need for regular check-ups, immunizations, etc.? If so, you're right in step with most of your colleagues. As a group, the eighty-eight North Carolina G.P.s scored much higher in this category than in any other. They were judged on two counts only: antenatal care and well-child care.

Over two-thirds of the men gave careful initial and follow-up examinations in pregnancy. And 87 per cent followed a schedule of prenatal and postpartum visits similar to that recommended by the American Committee on Maternal Welfare.

In addition, 93 per cent of them followed a set schedule of



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BRAND OF RESCINNAMINE

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a newer, better tolerated alkaloid of rauwolfia for improved control of tension and hypertension.

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MODERIL (brand of rescinnamine) gently brings relief to patients suffering from labile hypertension and anxiety, with less frequent and less pronounced side effects than earlier forms of rauwolfia therapy.1-5 It is reported that an appreciable number of patients who complain of mental depression, for example, while on other forms of rauwolfia. may be relieved of such symptoms by changing to rescinnamine (Moderil).4 In a recent comparative study involving tense patients "rescinnamine was preferred . . . by almost all the patients in the trial."5

Supplied: oval, scored, yellow tablets, 0.25 mg. and oval, scored, salmon tablets, 0.5 mg.

Hershberger, R. L.; Dennis, E. W., and Moyer, J. H.;
 Am. J. M. Sc. 231: 542 (May) 1966.
 Moyer, J. H.; Dennis,
 E. W., and Ford, R.: A.M.A. Arch. Int. Med. 26: 530 (Oct.) 1965
 McQueen, E. G., and Smirk, F. H.: Postgrad. M. J. 54: 85
 (Feb.) 1966.
 A. Smirk, F. H., and McQueen, E. G.: Lancet 2: 119
 (July 16) 1965.
 J. Hollister, L. E.; Stannard, A. N., and Drake,
 C. F.: Dis. Nerv. System 17: 289 (Sept.) 1966.

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1. See your doctor



2. Control your weight



3. Get enough rest



4. Keep physically fit



5. Ease up and relax | 6. Fight heart disease





help your heart fund... help your heart



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Lanteen jelly contains ricinoleic acid 0.50%, hexylresorcinol 0.10%, chlorothymol 0.0077%, sodium benzoate and glycerin in a tragacanth base. Lanteen jelly and flat-spring diaphragm sets are distributed by George A. Breon & Company, 1450 Broadway, New York 18, N. Y. (In Canada: E. & A. Martin Research Ltd., 20 Ripley Ave., Toronto, Canada:) Manufactured by Esta Medical Laboratories, Inc., Chicago 38, Ill. #TRADEMARK OF GROBAL A BRICH & COMPANY

#### HOW DO GOOD DOCTORS GET THAT WAY?

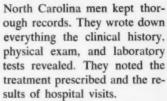
immunizations for very young children. One-fifth gave periodic well-baby check-ups as well.

#### Clinical Records

You may well argue that there isn't necessarily any connection between the scope of a man's records and his professional skill. Some doctors just happen to keep meticulous records. Others don't.

Though inclined to agree, the researchers included this activity because it "should provide some indication of the physician's thoroughness and attention to details which add up to good patient care." They found that the average man's performance in this category was on a par with his performance in the other five.

Seventeen per cent of the



A middle group, comprising about half the G.P.s, made brief notes on positive findings and medications prescribed.

The rest—some 36 per cent set down only scraps of information or none at all. Eleven men simply recorded the patient's name and the fee.

#### Better Than You Look?

At first glance, the survey findings are anything but encouraging. Yet the North Carolina observers themselves point out that a doctor may well give better care than his score on a test of this sort indicates. For example:

Judged by academic standards, the typical surveyed G.P. didn't handle emotional problems well. But this doesn't necessarily mean he muffed his traditional role as family friend and counselor. "Generally," say the researchers, "patients were very satisfied with their doctor and praised him openly . . . The sympathetic physician probably pro-





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To those who already own the famous Model 51 Viso-Cardiette, the new VISETTE can be an invaluable "companion" ECG—especially suited to use outside the office, or in hospital wards. Or, for those who prefer a larger instrument, using conventional 6 cm. width recording paper, the "51" is still available at \$785 delivered.

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when is the pollenation period of

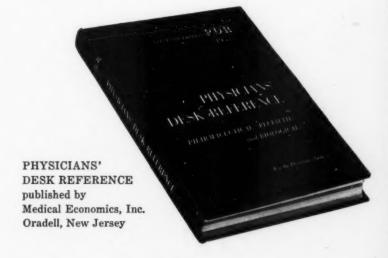
PROSTRATE PIGWEED

A schedule of the pollenation periods of various allergens is often most useful in tracking down the agents responsible for a patient's reactions. The list should be easy to use for quick reference, and be published in a form that can be kept handy at your desk.

You'll find just such a guide on Page 727 of the 1957 edition of PDR. It's one of the helpful features of the 37-page General Professional Information Section . . . and in PDR it's always at your fingertips.

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Ordinary desiccated thyroid and thyroid fractions have one thing in common: they sometimes produce a highly uneven calorigenic effect. Ordinary thyroid may drop the patient from a "high" of nervousness and tachycardia to a "low" of clinical ineffectiveness. And thyroid fractions tend to cause a far too rapid rise in the metabolic rate (with a consequent risk of cardiac involvement or other complications) followed by a sudden and marked relapse and distressing withdrawal symptoms.<sup>1,2</sup>

neither too much nor too little: Since it is highly purified and rigidly standardized, Proloid avoids not only the discomfort and danger of too much response, but also the disappointment of too little. At the same time, Proloid offers the complete thyroid complex, thus assuring the benefits of all the thyroid principles. smooth, predictable clinical response: Proloid gives the physician close control over therapy, permitting him to achieve the desired results tablet after tablet, bottle after bottle. Today, as through the years, Proloid is preferred whenever thyroid therapy is indicated.

Daily dose: Same as for ordinary thyroid,

References: 1. Beierwaltes, W. H.: J. Michigan M. Soc. 55:180 (Feb.) 1956. 2. Frawley, T. F.; McClintock, J. C.; Beebe, R. T., and Marthy, G. L.: J.A.M.A. 160:646 (Feb. 25) 1956.

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the total thyroid complex

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vides more emotional support than he realizes."

The study team was left with a high regard for the "selflessness" of many doctors. Says the report: "The irregularity and frequency of the demands made upon the physician's time are greater than in most professions. He is pictured in the minds of many as being ever available, never too fatigued to see one more patient, and having little personal need for rest or recreation. Many of the general practitioners participating in this study fit this picture."

The fact remains that not all the men showed the same degree of competence. Were the Rank V doctors more diligent than the others? Were they better trained? Or were they more interested in keeping up their standards? In what respects did their educational backgrounds differ from those of their less skillful colleagues?

I'll report answers to these and related questions in later articles. The answers may suggest changes you'll want to make in your own post-graduate study habits and practice methods.

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Slovin, I.: The Early Toxemias of Pregnancy, Delaware State M. J. 25:48 (Feb.) 1953.



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# When Should You Sue for an Unpaid Bill?

[CONTINUED FROM 163]

¶ The fee is exorbitant. (Ultimately, this question must be settled by the jury.)

Not all these are sound legal defenses; nor will they all be factually correct. But the defendant may raise them for nuisance value, if for no other reason. The doctor must be prepared to demolish such defenses one by one.

Suppose the doctor wins his suit. Suppose the patient still doesn't send a check. What happens then?

The next steps open to the doctor are these: (a) He can attach the defendant's wages; (b) he can execute a lien against his real estate; or (c) sometimes he can seize and sell some of the defendant's personal assets.

Attachment of wages often causes the defendant to lose his job. Will that do any good? Seizure of personal assets may unexpectedly publicize the doctor as a latter-day Simon Legree. A real-estate lien may be expensive, unwieldy, and ultimately uncollectible. So the method of collecting the judgment is best left to the lawyer who won the case.

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antifungal-antibacterial action potent antipruritic and anti-inflammatory effects

# STEROSAN' Hydrocortisone Ointment

A new, atrikingly efficient combination, STEROSAN-Hydrocortisone is particularly valuable in atopic and contact dermatoses and in those conditions requiring combined anti-infective and anti-infammatory action. STEROSAN-Hydrocortisone (chlorquinaldol GEIGY with hydrocortisone) is available as Ointment containing 3% STEROSAN and 1% hydrocortisone. Tubes of 5 Gm.

when the objective is potent antifungal + antibacterial action

## STEROSAN°

Cream and Ointment

STEROSAN® (chlorquinaldol GEIGY) is available as 3% Cream and Ointment.

when the objective is long-lasting relief of pruritus

### EURAX

Cream and Lotion

Provides 8-10 hours of effective relief with virtually no danger of sensitization or irritation EURAX (crotamiton GEIGY is available as 10% Cream and Lotion.

GEIGY ARDSLEY, NEW YORK



#### WHEN TO SUE FOR AN UNPAID BILL

If the timing is right, if none of the road-blocks to litigation is present, if the doctor is prepared to meet the suggested defenses, and if the judgment is collectible without unpleasant publicitythen the doctor can go ahead and start suit under the pilotage of his attorney.

Surprisingly enough, a good many sued patients return to the

suing doctor, even after losing the case. And they generally return with renewed respect for a man who doesn't undervalue himself, who demands honest payment for work honestly done, who doesn't sell himself short.

These happy results occur, however, only after doctor and lawyer have started suit at the strategic time.

#### Plumbing the Human Mind

My phone rang shortly after midnight. The caller, in a hushed voice, asked me to meet him at a street corner near his home. I was not to bring my bag.

I hesitated a moment, but then agreed to go.

At the appointed rendezvous, the man explained that he wanted me to see his father, who had recently been in a mental hospital and was now "acting up" again. The old man, it seemed, hated doctors. So I was to play the role of a plumber and observe him while checking the pipes. The son had even obtained what looked like a plumber's bag of tools for me to carry.

When we entered the house, the father was hunched in a chair with his feet drawn up under him. He shouted that there was water all over the place, that it was rising fast, and that he could drown before a plumber got there! His behavior was strongly suggestive of paranoia.

While there wasn't any water, of course, I pretended to fix a leak in the radiator. Outside, later, I gave the son my impressions. We agreed that the father should be recommitted. Next day this was done. —A. E. FRANKFURT, M.D. relaxes both mind and muscle

for anxiety
and tension in
everyday practice

- well suited for prolonged therapy
- m well tolerated, relatively nontoxic
- m no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- $\ensuremath{\mathbf{m}}$  chemically unrelated to phenothiazine compounds and rauwolfia derivatives
- m orally effective within 30 minutes for a period of 6 hours

For treatment of anxiety and tension states and muscle spasm

# Miltown\*

2-methyl-2-n-propyl-1,3-propanediol dicarbamate-U. S. Patent 2,724,720

Tranquilizer with muscle-relaxant action

DISCOVERED AND INTRODUCED

BY WALLACE LABORATORIES, New Brunswick, N. J.



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SUPPLIED: (Bottles 50 tablets)
400 mg. scored tablets
200 mg. sugar-coated tablets

USUAL DOSAGE: One or two 400 mg, tablets t.i.d.

THE MILTOWN®

Literature and Samples Available on Request



SCORED

TABLETS

CM-3670-R4

reports of clinical studies I "I have used meprobamate in my general psychiatric practice since April, 1955, and believe it to be [a] drug of choice for relief of tension, anxiety and insomnia."

Lemere, F.: Northwest Med. 54: 1098, 1955.

2 "... the patient [taking Miltown]
never describes himself as feeling detached
or 'insulated' by the drug. He remains...
in control of his faculties, both mental
and physical, and his responsiveness to other
persons is characteristically improved."

Sokoloff, O.J.: A.M. A. Arch. Dermat. 74: 893, 1956.

"Of special importance is the fact that Miltown does not appear to affect autonomic balance—which in alcoholics is often unstable . . ."

> Thimann, J. and Gauthier, J.W.: Quart. J. Stud. Alcohol. 17: 19, 1956.

4 "The [relative] absence of toxicity, both subjectively and objectively, is an important feature in favor of Miltown. In addition, there were no withdrawal phenomena noted on cessation of therapy, whether it was withdrawn rapidly or slowly."

Borrus, J.C.: J.A.M.A. 157: 1596, 1955.

"Miltown is of most value in the so-called anxiety neurosis syndrome, especially when the primary symptom is tension . . . Miltown is an effective dormifacient and appears to have . . . advantages over the conventional sedatives except in psychotic patients. It relaxes the patient for natural sleep rather than forcing sleep."

Selling, L.S.: J.A.M.A. 157: 1591, 1955.

## Miltown.



THE MILTON

2-methal-2-n-proposi-1 2-proposadiol disorbomate-II-S. Patent 2.721.780

Tranquiliser with muscle-relazant action
DISCOVERED AND INTRODUCED

BY WALLACE LABORATORIES, New Branswick, N. J.

## News [MORE NEWS ON PAGE 14]

#### Rural G.P.s Profiled In New Study

Rural G.P.s are the subject of a two-year study just released by the Pennsylvania state medical society. The study-conducted by Pennsylvania State University-is based on questionnaires returned by most of the 759 Pennsylvania doctors who practice in places smaller than 2,500. It provides one of the best-documented answers yet to the question: "What's rural practice really like?"

The average rural doctor has practiced seventeen years in the same place, the study discloses. He keeps office hours four evenings a week, and he's called out two or three evenings a week to make house visits.

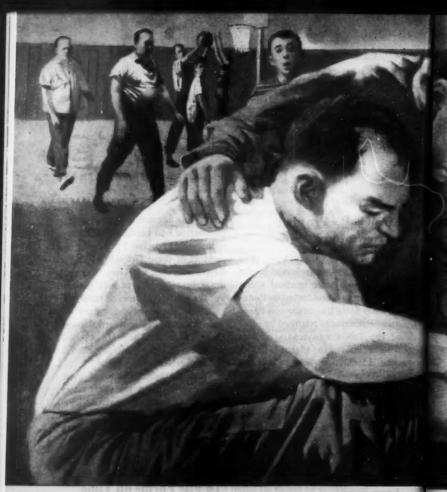
He's a true general practitioner. Each doctor classified his last three house calls and last three office visits: Out of a total of 2,653 cases reported, 23 per cent were upper respiratory, 17 per cent were cardiac, 13 per cent EENT, 10 per cent gastrointestinal, 6 per cent reproductive and pelvic. Other categories were all below 5 per cent.

Most of these G.P.s say they're happy with their lot. They "stressed the warm friendship of rural people ... the peace and quiet of rural life . . . and the satisfying nature of permanent doctor-patient relationships," says the study. If they had to move, 60 per cent say they'd choose another rural place.

As a further measure of their career satisfaction, the study notes that one in eight of the rural G.P.s had physician fathers-"but of their own grown sons, one-fourth are now physicians."

#### M.D.s Fined for Failing To File Forms on Time

Many states require the doctor not only to get a license, but also to make a periodic registration of the fact that he's still in practice. This requirement, in effect in New York, is more than just a nuisance there: Medical men are up in arms over



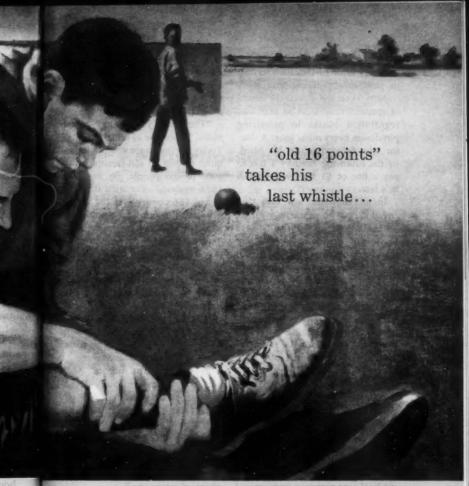
Spirit and the supplemental training and and training and an articular and an articular and an articular and an a

Traumatic periarticular fibrositis is a common penalty for those who go beyond their physical capacity. Early and adequate therapy with SIGMAGEN prevents the development of ligamentous calcification, periarthritis and its painful, sometimes irreversible, results.

SIGMAGEN provides doubly protective corticoid-salicylate therapy—a combination of METICORTEN® (prednisone) and acetylsalicylic acid providing additive antirheumatic benefits as well as rapid analgesic effect. These benefits are supported by aluminum hydroxide to counteract excess gastric acidity and by ascorbic acid, the vitamin closely linked to adrenocortical function, to help meet the increased need for this vitamin during stress situations.

The con Fol red Sub ly a is o dos:

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Therapy should be individualized. Acute conditions: 2 or 3 tablets 4 times daily. Following desired response, gradually reduce daily dosage and discontinue. Subacute or chronic conditions: Initially as above. After satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

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Precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN. for patients who go beyond their physical capacity... protective corticoid-salicylate therapy

corticoid-analgesic compound tablets

 Prednisone
 0.75 mg.

 Acetylsalicylic acid.
 325 mg.

 Aluminum hydroxide
 75 mg.

 Ascorbic acid
 20 mg.

90-J-457



the fines some of them are having to pay for registering late.

New York law directs the board of medical examiners to mail out registration blanks to practicing physicians every other year. A doctor who fails to return his blank by the following January 1 has to pay a fine of \$1 for every month he's late.

In addition, the law says that any doctor who practices without having registered shall be subject to a fine of "one dollar for each day that such practice shall continue. and if the same continues for more than thirty days the penalty thereafter shall be five dollars per day."

Recently a physician was fined \$278 in addition to his overdue registration fee: in another case, the fine was over \$300. In some instances failure to register appears to have been due to the fact that the registration blank was never sent to the doctor in the first place -but he still had to ante up.

#### How to Provide the Aged With Health Insurance

Insurance companies are extending medical care coverage to more and more older citizens. But one problem they face is the fact that as need increases, ability to pay premiums tends to go down. John H. Miller of the Monarch Life Insurance Company proposes the following as a solution:

Let old-age health insurance be funded during a person's active working years, precisely as pension plans are already being funded.

"The primary problem," Miller notes, "is not one of underwriting." Today the insurance companies are quite willing to sell health insurance to old people, he says. "A 1955 study . . . disclosed that 106 out of 186 companies . . . accept new applications for hospital expense insurance above age 60 . . . To a limited but increasing extent, group insurance policies . . . are including a conversion privilege which gives the retiring employe the right to purchase an individual contract."

The main difficulty, he explains, is that most old people can't afford to buy it: "Medical care [cost] tends to rise with advancing age ... This rise in cost occurs when earned income is generally declining or is entirely lacking."

But "the same mechanisms which have been developed for the provision of retirement income," Miller points out, "are obviously adaptable to providing additional amounts to be used for the purchase of insurance."

As Miller sees it, a policyholder -or his employer-would pay regular health insurance premiums plus an additional amount that would be put aside until retirement age. At that time he'd convert his old policy into one more appropriRequisites for EFFECTIVE LAXATION



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PHOSPHO SODA (Fleet)...

gentle, prompt, thorough and a laxative of choice for over 60 years.

Taken on an Empty Stomach...

at least 30 minutes before any meal, but preferably before breakfast.

#### Amply Diluted with Water...

Mix required dose with one half glass of cold water, follow with additional water.

SUGGESTED DOSAGE As a mild eliminant, two teaspoonfuls before a meal. For more pronounced hydragogue action, four teaspoonfuls before breakfast.

Children: Ten years or older, one half the adult dose; five to ten years, one quarter the adult dose.

Phospho-Soda (Fleet) is a solution containing per 100 cc., Sodium Biphosphate 48 Gm. and Sodium Phosphate 18 Gm.

In preparing for colonic surgery, preoperative administration of neomycin plus cleansing with Phospho-Soda (Fleet) suppresses intestinal bacteria. (1)

(1) Davis, J. H. et al., Surgery, 35:434, 1954



(Fleet)

C. B. Fleet Co., Inc., Lynchburg, Virginia Makers of the Fleet Enema Disposable Unit.

ate to his health needs in old age. And the money he'd already paid would be used to cover its cost.

#### New Code Governs Exams For Liability Lawsuits

In automobile accident cases, when an insurance company wants to make a physical examination of the plaintiff, it frequently runs into lawyer-created snags. Sometimes the attorney refuses to disclose the name of the plaintiff's physician; sometimes he insists that the examination be held in his own office.

Massachusetts doctors have adopted a code designed to end all that. The code specifies (1) that

the plaintiff's physician shall be told of the insurance company's request for examination; (2) that if the attorney won't tell the insurance company the name of the plaintiff's physician, no examination shall take place; (3) that examinations shall be held at a place mutually agreeable to both the plaintiff's physician and the insurance company's medical examiner.

"Seven out of ten judgments are based on medical testimony," explains the Massachusetts Medical Society. "It is a responsibility of the medical profession to see that ... examinations are made with exceptional care . . . under suitable conditions . . . MORE

ideal... And when dermatoses are in bloom

# **NEO-MAGNACORT**

topical ointment

### NEOMYCIN + the first water-soluble dermatologic corticoid

outstanding availability, penetration, therapeutic concentrations and potency - without systemic involvement. In 1/2-oz. and 1/6-oz. tubes, 0.5% neomycin sulfate and 0.5% ethamicort (MAGNACORT),

### for inflammation without infection MAGNACORT topical ointment

In 1/2-oz. and 1/6-oz. tubes, 0.5% ethamicort (hydrocortisone ethamate hydrochloride).



PFIZER LABORATORIES (Pfizer) Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

\*Trademark

# Why are <u>PERCODAN</u>° Tablets better for pain?

SPEED OF ACTION	WITHIN 5-15 MINUTES1-3	almost immediate relief of pain
DURATION OF EFFECT	6 HOURS AND LONGER1-3	sleep uninterrupted by pain
THOROUGHNESS OF PAIN RELIEF	USUALLY COMPLETE <sup>1-5</sup>	reliability of pain relief
INCIDENCE OF CONSTIPATION	RARE1-3	excellent for chronic and bedridden patients

# Better than codeing plus APC"

Average adult dose: 1 Percodan\* Tablet every 6 hours.

Supplied: Scored, yellow oral tablets, containing salts of dihydrohydroxycodeinone and homatropine, plus APC. May be habit-forming. PERCODAN Tablets are available at all pharmacies.

References: 1. Piper, C. E., and Nicklas, F. W.: Indust. Med. 23:510, 1954. 2. Blank, P., and Boas, H.: Ann. West. Med. & Surg. 6:376, 1952. 3. Chasko, W. J.: J. District of Columbia Dent. Soc. 31:3, No. 5, 1956. 4. Cass, L. J., and Frederick, W. S.: M. Times 84:1318, 1956. 5. Bonica, J. J.: GP 10:35, No. 5, 1954.

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New York

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ENDO LABORATORIES, Richmond Hill 18, New York

\*U.S. Pat. 2,628,185

# because TACE

# in body banks"...the menopause is

Radioautographs
prove
unique
TACE
fat storage\*



\*Tests performed for The Wm. S. Merrell Company by an independent radiological laboratory. Radioactive iodine supplied by the U.S. Atomic Energy Commission, Oak Ridge National Laboratory.



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Section of omental fat containing TACE tagged with I131 (A) leaves radioautograph evidence (B) of TACE storage in body fat. In a control study I131 was administered without TACE. There was no evidence of the iodine in any of the body fat depots. Radioautographs prove that TACE is stored in "body banks," supporting the fat bioassay findings of Greenblatt1 and Thompson,2

1. Greenblatt, R. B., and Brown, N. H.: Am. J. Obst. & Gynec. 63:1361, 1952. 2. Thompson, C. R., and Werner, H. N.: Proc. Soc. Exper. Biol. & Med. 77:494, 1951. 3. Woodhull, R. B.: Obst. & Gynec. Surv. 3:201, 1953. 4. Ausman, D. C.: Wisconsin M. J. 41:190, 1954. 5. Bickers, W .: Scientific Exhibit, Southern Med. Assoc., Dallas, 1952. 6. Benson, R. C., and Garetz, J. W.: J. Clin. Endocrinol. 13:258, 1953. 7. Allen, W. M.: TACE Symposium, January, 1952. 8. Editorial: Management of the Menopause, J.A.M.A. 158:566, 1955. 9. Edwards, B. E.: J. Indiana M. A. 47:869, 1954. Gillam, J. S.; Hunter, G. W., and Darne, C. B.:
 J. Clin. Endocrinol. 14:272, 1954. 11. Nulsen, R. O.; Carmon, W. B., and Hendricks, H. O.: Am. J. Obst. & Gynec. 65:1048, 1953.

TRADEMARK: TACES

The only oral estrogen giving prolonged relief for months after cessation of therapy. An average duration of relief from menopausal symptoms of 2.95 months after discontinuance of TACE therapy has been reported.3 This prolonged response to TACE encourages adaptation to the normal postmature state, so that further courses of therapy are not usually required.4

The only oral estrogen that is released from fat depots1-7 simulating ovarian secretion. The unique fat-storage property of TACE produces a clinical response free from the gross variations in estrogen stimulation common with other estrogens.3 Symptomatic relief is steady and measurable, subjectively and objectively.3-5, 10

TACE, only orally administered, is notably free from pituitary activity and other side effects. In four series, totaling 257 patients, 250 TACE-treated cases experienced no withdrawal bleeding,1-9,11

Only TACE has all three requirements for effective hormonal treatment in the menopause.8 1. Long-acting-TACE is the only long-acting orally administered estrogen. 2. Orally administered-TACE is administered only by mouth and stored in body fat.1 3. Inhibits pituitary activity-in experimental animals TACE has less tendency to produce pituitary hyperplasia than other estrogens.9

Supplied: Capsules containing 12 mg. TACE, in bottles of 70 and 350.

Average TACE dosage: 2 capsules daily for thirty days. Severe cases may require additional short courses.

A 15-minute color film, with sound, on the endocrine trigger mechanism of lactation is available for your use. The film, titled "TACE for Suppression of Lactation," was prepared with the assistance of Robert W. Kistner, M.D., Assistant in Gynecology, Harvard Medical School, Boston. For use of the film, write: Department of Professional Service, The Wm. S. Merrell Company, Cincinnati 15, Ohio; or contact your Merrell Service representative.

THE WM. S. MERRELL COMPANY New York · CINCINNATI · St. Thomas, Ontario

#### You can use and recommend Lavoris with confidence!



#### A MOUTHWASH,

to be really effective and worthy of your recommendation, must be detergent, deodorant and astringent.

Only by combining these

three properties can it accomplish thorough cleansing and stimulation with resulting improvement of tissue tone and resistance.

#### THE UNIQUE

chemo-mechanical cleansing action of Lavoris makes it a valuable adjunct to oral hygiene. It changes sticky, mucoid deposits into a non-adherent form.

These deposits, with their accumulation of epithelial debris and putrifying food particles, are then easily washed away.

#### THE ASTRINGENT

action of Lavoris leaves mouth and throat fissues stimulated and refreshed. And because Lavoris is pleasant tasting, patients will gladly co-operate.

LAVORIS

ACTIVE INGREDIENTS: Zinc chloride, formaldehyde, menthol, oils of cinnamon and cloves, saccharin and alcohol 5%.



#### AVAILABILITY:

Samples on request. A professional gallon of Lavoris is available to practicing physicians only. Order direct on your protessional stationery. including remittance at \$2.50 per gallon (delivery prepaid). If you have not received one, a handy dispenser pump for the gallon will be sent with your order. Trade sizes: 4 oz., 9 oz., 20 oz. bottles at all drug stores.

THE LAVORIS COMPANY

#### NEWS

"Only an examination in a physician's office, hospital, or the plaintiff's home if he is unable to travel, together with the collaboration of the plaintiff's physician, can . . . insure a report that is fair to all parties concerned."

Violations of this code, the society adds, should be reported to the Secretary of the Massachusetts Medical Society.

#### Two Towns Fight Over Who Gets Doctor

Dr. Raymond D. Evans of Clayton, Ga., is probably the most sought-after man in north Georgia. Recently, the 35-year-old generalist served as grand prize in a tugof-war between the citizens of his own Clayton (population 1,302) and neighboring Blairsville (population 430) just a few mountains to the west.

It all started when a fifty-man delegation from doctorless Blairs-ville called on Dr. Evans and asked him to change towns. As inducements, they offered to give him an office and a rent-free home.

Word of their visit spread fast. Although Dr. Evans had only been practicing in Clayton for about a year, his neighbors had no intention of giving him up. The next Sunday, after church, virtually the whole town turned out to ask him to stay.

They filled his house, spilled over into the yard, blocked sideroads and detoured traffic on the main highway through town. Among hysiolainravel, on of to all socio the

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vitamin protection the baby needs

Tri-Vi-Sol°

3 basic vitamins...A, D, C

Poly-Vi-Sol®

6 essential vitamins ... A, D, C, B,, B<sub>2</sub> and niacinamide

Deca-Vi-Sol®

10 nutritionally significant vitamins, including A, D, C, B1, B2, niacinamide, biotin, pantothenic acid, 8, and stable B<sub>13</sub>



· highly stable - refrigeration not required

· readily accepted - exceptionally pleasant flavor, no unpleasant aftertaste

· full dosage assured - can be dropped directly into baby's mouth In 15 cc., 30 cc. and economical 50 cc. bottles

with calibrated plastic 'Safti-Dropper'

12537

MEAD JOHNSON SYMBOL OF SERVICE IN MEDICINE

# Now from American Sterilizer\_

#### \*MODEL 613-R PORTABLE HIGH-SPEED AUTOCLAVE

New HIGH in performance New LOW in cost



The newest product of the world's largest manufacturer of Pressure Steam Sterilizers

See your authorized
American Sterilizer Dealer or write
for Bulletin DC-410.

## Compare

#### THESE FEATURES:

- All Stainless Steel
  For durability and easy cleaning
- Positive Sterilization
  Pressure steam at 250° F. to 270° F.
- Greater Capacity
  Holds three large trays (6" x 13")
- Fast
- Reaches 270° F. in approximately seven minutes
- Automatic
   Times any selected sterilizing cycle
- Cool and Dry
  Dries instruments or supplies by ex-
- hausting steam and residual water back into water reservoir . . . NOT into room
- Safety-Lock Door, Adjustable Thermostat and Accurate Temperature Gauge

Automatically "burn-out" proof



AMERICAN STERILIZER

ERIE . PENNSYLVANI

them were not only his own patients, but also patients of the other three doctors in town.

Confronted with this mass show of faith, Dr. Evans gave up. To the cheering crowd, he said, "I must stay here now."

Ray Evans—shown here with the model-A Ford he uses to navigate muddy country roads—insists that the other physicians in Clayton command as much loyalty as he does. He's covinced that it's not personal popularity, but good medical care, that brought the town to his door.

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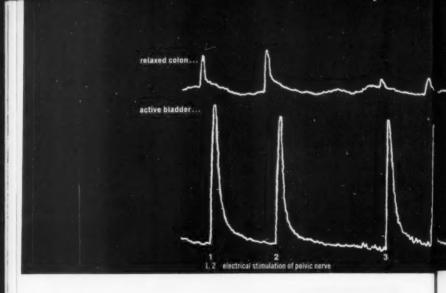
"I didn't want to leave Clayton, but I felt those folks in Blairsville needed a doctor," he explains. "It was that and not their promises that made me decide to move my practice. But of course, after what the people in Clayton did, I can't possibly leave."

#### Car Dealers Are Ready With Big 'Discounts'

You'll probably be offered a whopping discount if you go shopping for a new car this spring. Dealers are itching to make up for rela-



'MOST WANTED' physician in north Georgia—with two towns vying for his services—is Dr. Raymond D. Evans, shown here making a house call. The 30-year-old Ford may help to explain his popularity: It carries him over muddy mountain roads, where a low-slung modern car might bog down.



#### for functional and organic colon disorders

#### effective, selective therapy

Selective action focused on the colon avoids widespread interference with normal autonomic function. In most studies no significant side effects attributable to CANTIL were encountered. Less than 10 per cent of patients had any complaints. Dryness of the mouth occurred in some patients but this was usually mild or moderate and often transitory. Blurring of vision was noted occasionally, most often in ulcerative colitis. Urinary retention was extremely rare.

How to use CANTIL Prescribe one or two tablets three times a day, preferably with meals, and one or two tablets at bedtime for patients with ulcerative colitis, irritable colon, mucous colitis, spastic colitis, diverticulitis, diverticulosis, rectospasm, diarrhea following G.I. surgery, bacillary and parasitic disorders.

#### CANTIL-two forms

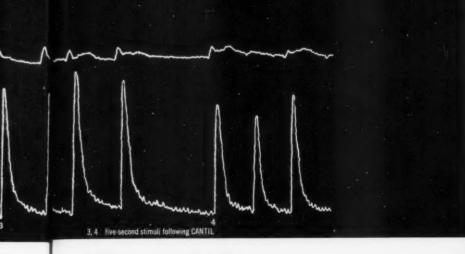
CANTIL (plain) -25 mg. of CANTIL in each scored tablet-bottles of 100.

CANTIL with Phenobarbital -25 mg. of CANTIL and 16 mg. of phenobarbital (warning: may be habit forming) in each scored tablet-bottles of 100.

CANTIL is the only brand of N-methyl-3-piperidyl-diphenylglycolate methobromide.

For more detailed information, request Brochure No. NDA 16, CANTIL Lakeside Laboratories, Milwaukee 1, Wisconsin





## Cantil for the colon

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1357

Clinical results from reports on 309 cases

	number of patients	diagnosis	number improved
relieves	42	ulcerative colitis	32
crampi	40	spastic colitis	39
bloating	47	functional colopathies (primary spastic colon)	35
curbs	2	mucous colitis	2
diarrhea	7	colon stasis (hypertonic)	6
restores	124	irritable colon	84
normal tane and moultry	8	unstable colon	7
	6	diverticulitis	6
	5	reserpine-induced diarrhea	5
	9	diabetic diarrhea	8
	8	diarrhea after G.I. surgery	5
	11	diarrhea	6

tively poor sales during the fall and winter.

But in most cases, as a recent study by The Wall Street Journal points out, you won't actually be getting a real discount. For the dealer may have jacked up the list price by several hundred dollars to offset it.

To discover the extent of this practice (known in the trade as "packing"), Journal reporters in more than a score of cities and towns posed as car buyers out for a bargain. They found price-packing almost universal.

A typical case was that of a St. Louis Buick dealer: While the suggested manufacturer's list price for a four-door Special (including radio, heater, automatic transmission, and a dealer profit of about 24 per cent of list) is \$3,035, this dealer started with a list price of \$3,431. But to clinch the sale he was ready to let the car go for \$2,690—thus eliminating the pack and even part of his real profit.

Since the dealer who thus packs on \$400 one minute may turn around and knock off at least that much the next minute, why does he bother with the price-boost gimmick at all? Reasons are mainly psychological. Explained one dealer to a reporter:

"A customer's car may be worth only \$300, but if you offer him that he'll faint and run out to some other dealer. So instead of allow-

ing a \$300 trade-in and selling the new car for \$2,100, you step it up to \$3,000, put on a wide smile and offer him \$900. He's happy and you get the sale."

What such maneuvers mean to you is this: Car dealers are in a dickering frame of mind; and chances of making a "deal" are excellent if you're willing to work at it. In any case, you'll do well never to accept a dealer's first offer.

#### New British Specialty: **Taking Night Calls**

Night calls, the bane of any family doctor's existence, are especially troublesome in Britain. The National Health Service there requires physicians to be available at all hours. So a new kind of specialist has begun to appear in and around London: the specialist in night calls.

The idea of having some doctors do nothing but take others' night calls has been tried half-heartedly in America. But there's nothing half-hearted about the London system. Termed the Emergency Call Service, it employs a full-time corps of night-duty doctors.

A central office takes phone calls and relays messages to doctors standing by either in the office or in radio-equipped patrol cars. Each car is supplied with a medical emergency kit, refilled daily by E.C.S. There are times when nightg the it up and and

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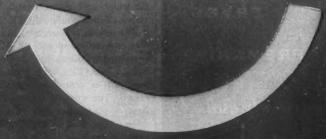
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call physicians are sent from case to case all night long, without once returning to headquarters.

E.C.S. was organized a little over a year ago by Drs. Arthur Bane and Montague Solomon. Originally it served only West London; today it covers the entire metropolitan area. Over 400 doctors, representing at least a million patients, now subscribe. They pay anywhere from about \$1 to \$7.50 for stated periods of coverage. During such periods, the telephone company simply reroutes all their phone calls to E.C.S.

The service, incidentally, is in no way government-sponsored. When socialized medicine first came to Britain, the G.P.s were promised some sort of centralized night-call set-up. The current organization came into existence only after the doctors had given up hope that the promise would be fulfilled.

#### Polio Foundation Said To Mislead Doctors

The Polio Foundation "has seen fit to decide what physicians of this country shall or shall not read about the Salk vaccine. Its principle seems to be . . . that American physicians are not capable of being trusted with the full story."

This complaint is voiced by Dr. Herbert Ratner, a public health officer of Oak Park, Ill. What rouses his ire is a booklet put out by the Polio Foundation: Number 4 of a series called "Information for Physicians on the Salk Poliomyelitis

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Nutritionists agree that vitamin B deficiencies are seldom seen singly. Two or more B-complex factors are usually involved. B-complex multivitamin preparations, despite similarity of published formulas, do not agree quantitatively.

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#### NEWS

Vaccine." This booklet, says Dr. Ratner, "flagrantly violates editorial standards by deleting from a purportedly and otherwise completely reproduced article a short paragraph [warning] against the unwary acceptance of the conclusions."

The article in question is a report on the incidence of polio in 1956. The omitted paragraph explains various discrepancies in the statistics, and advises that "interpretations of the results must necessarily be guarded." Dr. Ratner seems convinced that the omission is intended to deceive physicians—who, he points out, "have the real responsibility for the public's health.

"It is ironic that the regimentation of physicians' minds—the medical profession's greatest fear —comes, in this instance, not from government officials whom we can at least vote for or against every four years and whose budget we can watch over, but from a socalled voluntary agency, whose hierarchy apparently enjoys a lifelong tenure and whose expenditures do not have to be accounted for."

#### Labor Leader Says M.D.s Stymie Prepayment

Many union leaders tend to think that prepayment health plans, and the Blue plans in particular, are designed primarily for the benefit of doctors, rather than their pa-



(AND A GLANCE AT THE FORMULA SHOWS 2 REASONS WHY)

each tablet contains:

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1. Weil, L. L.: J. Florida Acad. Gen. Pract. 4:9 (July) 1954. 2. Williams, Henry L.: J. Michigan State Med. Society 51:572-576 (May) 1952.

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#### NEWS

tients. This attitude was expressed recently by Leonard Woodcock, vice president of the United Auto Workers. In a speech to labor health administrators, he accused the Blue plans of trying "to superimpose the modern concept of prepayment on an archaic system of solo practice."

The plans have "capitulated completely," he says, "to [those] elements in organized medicine which, less than twenty years ago, tried to strangle Blue Cross and Blue Shield in their infancy... A brief period of brave experimentation has given way to premature senility."

In Woodcock's view, the standard prepayment plans suffer from two major flaws—both of which stem directly from the fee-for-service system:

The first of these flaws, he believes, is the plans' failure to assume "their proper responsibility" for the *quality* of the care they provide. Because they lack "necessary" medical controls, Woodcock feels,





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Your obese patients may resist weight reduction because they fear losing the emotional security involved in overeating. AMBAR™ Tablets or Extentabs° add incentive to weight reduction, give the patient a better chance of holding off the disabling effects of continued overweight and obesity. Methamphetamine, a more potent CNS augmenter than amphetamine yet producing less cardiovascular effect, is combined with phenobarbital — result, mood amelioration without undesired excitation — weight reduction without jitters.

#### **Ambar Extentabs**

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# When she's stymied by Temptation



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they "offer an irresistible temptation to some practitioners to perform unnecessary surgery."

The second flaw of the fee-forservice plans, the labor leader contends, is that they cost too much. Says he: "People need health insurance to provide valid health services—not added economic pressures when they are sick...

"Unions... have had to buy the best benefits available," he goes on. "The best available coverage is none too good . . . There is a great gap between the medical care generally available and that which we as a nation have the scientific and technical know-how to provide." He warns that organized labor intends to fill that gap by promoting schemes for comprehensive prepaid care. Only in this way can labor's "reasonable needs . . . for health security" be met, he concludes.

## Surgeon Operates in Davey Jones' Lockér

It's the vocation of surgeons to get below the surface. It's also the avocation of Surgeon George Crile Jr. of Cleveland. He spends much of his spare time deep-sea diving.

On vacations, Dr. Crile prowls around two or three fathoms down, spear-fishing, photographing, prospecting for sunken treasure—or just enjoying the company of his wife and four children, who often follow him into the lower depths. By now the Criles have set

flippered feet on the floors of three oceans. They've gone overboard in such off-beat, off-shore spots as the Coronado Islands off Mexico, the Dry Tortugas off Florida, the Isle of Lavezzi off Corsica.

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Even under water, George Crile never forgets he's a surgeon. He tells of having once tried a thyroidectomy on a female ray he'd just speared. He's also amputated an octopus' tentacle—with his bare hands.

Inevitably, he caught "gold fever." A rusty anchor, a coral-encrusted cannon on the ocean bottom, brought visions of wrecked treasure galleons. So he made a vacation switch to a radically different kind of operation: ship salvage off the Florida Keys.

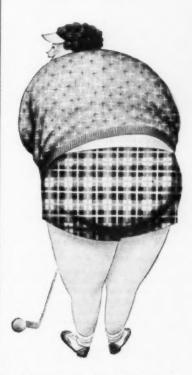
His first wreck proved to be a slave ship of 300 years ago. It yielded a prize of antique, agedin-the-water ivory: thirteen valuable tusks, some weighing fifty pounds.

He lavished his next vacation on a wreck that was littered with ingots. If silver, instead of iron, they would have been worth enough to electrify any doctor's relations with the Bureau of Internal Revenue: possibly \$2,000,000. As it was, the ingots and other relics helped identify the sunken ship as the three-masted, square-rigged British manof-war H. M. S. Looe, sunk in 1744; and Dr. Crile had the nontaxable satisfaction of seeing the Looe relics exhibited at the Smithsonian Institution.

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**Dosage:** One application every other night until a total of 6 has been reached. This treatment may be repeated if necessary.

**Supplied** in 1½ oz. tube with 6 disposable applicators. Instructions for use are included with each package.

\*Gardner, H. L., and Dukes, C. D.: Am. J. Obst. & Gynec. 69:962 (May) 1955.

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FROM THE PUBLISHER

#### **About Those Anecdotes**

Many a MEDICAL ECONOMICS reader credits "those jokes" with adding a welcome flavor to the magazine's pages. Actually, we don't think of the anecdotes we publish as "jokes." What we're after is not a set of contrived wisecracks. Instead, we want to report human experiences that reflect humor, authenticity, and a real insight into the doctor's life.

Of the several hundred stories that physicians send us each month, some are wild, some are wonderful, some are . . . whew! But a good many miss the basic point mentioned above about medical humor. As a result, only 5 per cent draw a thumbs-up from the editors-and a check ranging from \$25 to \$40 for the doctor who sent the story in.

The most sure-fire categories seem to be these:

1. Unusual patients. Perhaps you remember the story of the fortyish matron who, when told she was pregnant again, wailed: "I just

don't think I can stand fifteen more years of P.T.A.!" Or the one about the colored mother who was coaxing her obstinate youngster into being breast-fed. She caused quite a stir in the doctor's waiting room by threatening: "Take yo' dinnuh, chile, or yo' mammy will give it to the doctuh!"

2. Unusual physicians. Consider the surgeon who inadvertently nicked the bladder during a laparotomy. After the damage had been repaired, he turned in a report reading: "Exploration of the bladder failed to reveal the presence of stones." And don't forget the young doctor who livened up a dull medical meeting by showing a birth-of-a-baby film in reverse.

Such anecdotes often travel far. Two books have been based on them. But the greatest compliment -and one we encounter not infrequently-is to have some physician gleefully tell us a "new story" we recognize as one of MEDICAL ECONOMICS' old ones. That's when we know the flavor really lasts.

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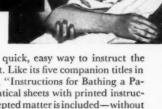
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